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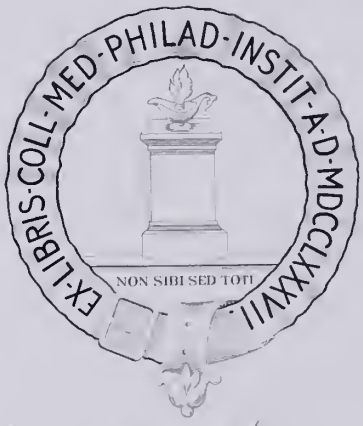

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WISCONSIN MEDICAL JOURNAL

JANUARY 1980

• The 80s—a glance backward and a glimpse forward/President Treffert • Panel system and the non-participating physician/Doctor Quirk • From here to eternity . . . the development of the "Super-Rule"/Mr Jensen • Official notice re proposed constitutional amendments affecting Unified Membership rule • Biographical sketches of nominees for SMS offices • Annual Meeting program highlights • Tax tips from SMS Services

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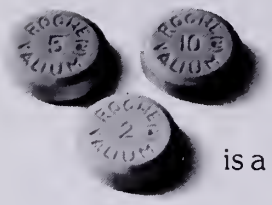

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President's Page

Darold A Treffert, MD

The 80s—a glance backward and a glimpse forward

The best qualification to be a good prophet is to have a good memory, since history does, with certainty and regularity, repeat itself. Exactly 100 years ago, on ushering in the 1880s, Dr Walter Kempster, the first superintendent of Winnebago State Hospital, made an interesting observation, challenge and charge:

> "Who can think of the number of unfortunate beings now confined in the receptacles of the different counties in this state, and realize in the most remote degree, the sorrowing hearts their misfortunes have created; of the hopes once bright now dashed; of ambitions which lured beyond strength; of life's work begun but left unfinished; of affections ripened only to be blasted . . . Who can consider these calamities of our fellow mortals, rendered insane by no act of their own, unwittingly thrown upon the charity of the state, bound by the unyielding fetters of a terrible disease, knowing not how soon it may be our turn to take our place among these pitiable creatures; who can think of these things and turn idly away, closing eye and hand withholding that which is known to be required to make life comfortable? We can conceive no argument, economical or humanitarian, that can be adduced to show why aid should be postponed; why the sufferer must be compelled to suffer on."

Every day in my practice I see patients with hopes once bright, now dashed. Every day I see persons whose ambitions have lured them beyond their strength; sometimes those persons are my colleagues. Every day also I see patients whose affections have been ripened only to be blasted. So in this last 100 years, some things, like illnesses, have changed very little. Our charge in the 1980s, looking ahead, is much like that of the 1880s—"to cure sometimes, to help often, to comfort always." I know of no reason either why, when it is available, aid should be postponed; or why, when it could be different and we can make that difference, the sufferer should be compelled to suffer on.

But like myself, Doctor Kempster also looked backward on that day in 1879 and he delineated an interesting yardstick with which to measure ourselves for the 1980s and the years beyond. This was his glance backward:

> "The results attained in the past one hundred years are certainly gratifying, and should stimulate us to carry forward the good work, constantly endeavoring to advance the interest of the people in whose cause we are all engaged, so that, when the record of the next one hundred years shall be written up, it may be said of us, that our eyes were not altogether blinded, or that, with the light we had, our opportunities were not unimproved."

The 80s bring splendid opportunities, some of them cleverly masquerading as insolvable problems, to use John Gardner's words. We will struggle with changing delivery systems, planning hassles, bureaucratic morass, maldistribution of physicians, questions of whether we have too many or too few doctors. The proper role and function of a whole host of "physician extenders," or some would say would-be physicians, will probably be the most vexing and pivotal question of the 80s for all of medicine. Perhaps also, it will finally be decided whether medicine is to be a free enterprise system to be policed by the FTC, or whether medicine is a utility to be regulated by HEW; presently, medicine is totally neither, but being controlled as if it were both. And finally perhaps we can take the versus out of prevention-versus-treatment and balance those equally legitimate functions in some reasonable manner. Maybe we can even decide whether the correct spelling is holism, wholism, or (w)holism; (frankly, who cares).

But you see the reason for, and the survival of,

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medicine has always been, and will continue to be, quality patient care. Whatever else we do, or change, we dare not change our unrelenting focus on doctor/patient care, one-on-one. That is the essence of medicine, its creation, its continuation, its purpose, and its perpetuation.

What can each physician do in the decade ahead to keep healing as uncluttered as possible for both patients and doctors, and for present patients as well as future patients? Practice the best quality of medicine, one-on-one, as is humanly, humanely, and professionally possible. That will ensure, I am certain, the thriving, as well as the mere surviving, of medicine. But survival is not the reason for doing it. The reason is, as Doctor Kempster stated in his forward glance, so that the sufferer is not compelled to suffer on. That's reason enough. Survival comes as a byproduct.

Quality patient care—competent, compassionate, dedicated and gentle, whether entering the 1980s or the 1880s, is the essence of what we must do, and is the essence of what has preceded and what must follow.

Quality patient care is the unswerving challenge, responsibility, purpose, and privilege of this profession, in this or any other of the 80s of the past or the future. If we do that, and concentrate on that as individual practitioners and as a whole medical society, then it can be said of us, when the record of the next 100 years is written, that our eyes were not altogether blinded, or that with the light we had, our opportunities did not go unimproved. ■

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CORRECTION. In the article "The Use of Esophageal Manometry in Children," written by Doctors Steven L Werlin, Wylie J Dodds, and Walter J Hogan, in the September 1979 issue of the *Wisconsin Medical Journal*, Figure 2 (hiatal hernia) appeared upside down. This was the printer's error for which the WMJ apologizes. Anyone wishing reprints of the article with the figure in proper position, please contact Doctor Werlin at Milwaukee Children's Hospital, 1700 West Wisconsin Ave, Milwaukee, Wisconsin 53233.

Editorials

Editorial Director: WAYNE J BOULANGER, MD

The "semi-private" room

Hospitals have come a long way in the realm of patient comfort since the 1930s. Gone (for the most part) are those early morning enemas and those cold, enamelled private receptacles. Gone is the cruel doctrine of prolonged bed rest following major surgery. Gone is that awful hospital atmosphere that combined the odors of antiseptics and floor polish and sick mankind into an unforgettable overpowering effluvium (perhaps a mixed blessing since it did serve to keep visitors from staying too long).

There remains, however, a vestige of primordial hospital care that should have been banned a generation ago but has instead gained impetus anew—the "semi-private" room. The new impetus, of course, comes from insurance companies and government who will pay toward a private room only that amount which is equal to the cost of a semi-private room. In a few instances, smart hospital planners have struck a blow for patient comfort by building new hospitals all of whose rooms are private, thus forcing insurance companies to cover the entire load, but these are rare.

The patient whose doctor practices in a conventional hospital is often at the mercy of an insensitive admitting clerk who may berive perverse pleasure from forcing him to lie trapped in traction scarcely three feet away from a nicotine addict or a senile babbler or family man with 13 kids, all of whom visit at the same time, or a cancer patient in his death throes.

The irony of it all is that the truly obnoxious patient always requests a "semi-private" room and then proceeds to keep it private by being totally impossible to live with.

One would think that charge nurses would overrule the admitting office and try to match their patients' ages, afflictions, and personalities and shift them around accordingly. Instead they sometimes do just the opposite. I have had patients given roommates who were terminal when admitted, who subsequently died after keeping my patient awake all night, only to have the process repeated the next day with another terminal admission.

The obvious solution is simply to phase out the private room. This will take a generation, though. In the meantime the consumer can bring pressure to bear on the insurance carrier to offer coverage which for a slightly higher fee will cover a private room. And more private rooms can be made available if hospital administrators, in those areas where occupancy rates are low, will simply convert their "semi-private" rooms to private.

–WJB

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Tight budgets and litigation

A few years ago when membership in the various medical societies included almost all of the eligible physicians, a balanced budget with adequate reserves was the rule. If activities within the organization required retention of legal counsel, there was always enough money to pay the lawyers' fees. And if in the process of policing ourselves we found it necessary to take punitive actions against members, we didn't have to stop and count our money before proceeding should they threaten to bring their attorneys along to the hearings.

Now, however, the situation has changed due to the inflated costs of litigation measured against membership dues income; and ethical practice committees and boards of directors are stymied because they believe they can't afford to go to court anymore. Physicians who should be disciplined realize this, simply threaten suit, and are allowed to go their way for unduly long periods until criminal proceedings are instituted. Many minor miscreants who don't come under the scrutiny of the district attorney continue unabated in their marginal but definitely unethical practices while we are helpless to do anything about them.

This same fear of the high cost of litigation comes up whenever we wish to challenge a government ruling. There the ludicrously paradoxical situation of paying the costs of legal action

against ourselves through our taxes while we can't afford to pay our own advocates exists—and is getting worse.

There seem to be only two choices in this situation. We must either be willing to pay assessments at those times when costs of litigation are incurred, or we must call upon those agencies which exist outside of medicine's family to launder our dirty linen earlier and more often. An unacceptable choice would be to continue to do nothing and back down everytime we're challenged—WJB

Potboiler

A potboiler is defined as any literary or artistic work done merely to make money rather than for artistic excellence or love of the work. The term certainly is appropriate for that group called The Who. It is doubly appropriate because of the undoubted use of pot by their audience that resulted in eleven young people being stomped to death.

The subject of the eleven deaths at the stampede in Cincinnati has been covered from every angle by the press. That these masochists were striving for front row positions in order to be subjected to a horrendous cacophony of caterwauling is up to their own lack of discretion. If anyone in industry was subjected to an equivalent level of amplified decibels, it would bring OSHA screaming into the offending factory.

The news releases all reported that alcohol and marijuana were in heavy use by the crowd. This is probably the largest single factor resulting in the tragic deaths.

The really sad situation, however, is that more and more individuals and some publications are campaigning for the legalization of marijuana. There must be wider dissemination of the effects of marijuana in children and adolescents since its use is spreading to subteeners. It is known that marijuana affects learning, memory, and intellectual performance. Its use during the school day is definitely detrimental. Marijuana impairs perception and performance while driving. This has been shown in a study of drivers involved in fatal accidents. There is evidence that some regular heavy daily users do develop psychological dependence on marijuana. Marijuana smoking has been shown to interfere with lung function, and animal studies show the likelihood of lung damage from habitual use similar to that from heavy cigaret smoking. Additional studies have linked marijuana with reduced levels of testosterone in men and reduced fertility in women. The use of marijuana during pregnancy would seem particularly undesirable.

The medical profession must take a much more active role in spreading the word about marijuana and stress that it is not simply a harmless bit of recreation. It must also present a united voice of protest whenever liberalized legislation favorable to malicious marijuana is proposed.—VSF ■

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Suppositories/Cream

for symptomatic relief

- Effectively reduces inflammation and edema
- Rapidly relieves pain and itching

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
CAUTION: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg, bismuth subgallate, 2.25%, bismuth resorcin compound, 1.75%, benzyl benzoate, 1.2%, Peruvian balsam, 1.8%, zinc oxide, 11.0%, also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg, also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnosis or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01); with plastic applicator, detachable label.

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Letters

Panel system and the non-participating physician

The Medical Liability Committee of the SMS Physicians Alliance wishes to bring a serious matter to the attention of all Wisconsin physicians. The Committee has noted that on several instances physicians have been unavailable for service on the panels created under the medical malpractice legislation of 1975. As has been publicized by SMS in the MEDIGRAM, the panel system has been very effective at getting cases tried rapidly (usually within 4-6 months) and at expediting the process of medical litigation. Recently, however, the administrator of the panel system, Mr Jeffrey Kravat, has noted that it has been difficult to obtain physicians for service on the panels. This problem is especially acute when it involves specialties with relatively few physicians.

Our State has indeed been fortunate to have weathered the malpractice crisis of 1975 and to have constructed a medical malpractice system which has withstood constitutional challenges and which has resulted in rapid resolution of medical litigation. Our system has worked to this point and gives a sharp contrast to, for instance, Pennsylvania, where a backlog of well over 2000 cases exists.

The Medical Liability Committee will be taking up the matter of the non-participating physician with the administrator of the panels as well as the heads of the various specialty sections. Early in 1980 this most pressing problem will be addressed by the Committee.

It is our urgent concern that the panel system continues to operate efficiently and fairly. It is our concern that the medical malpractice climate in our State not be threatened again with a crisis. The last crisis was not precipitated by physicians; the next one might be.

It is the *duty* of a physician to serve on the panels when called upon. It is the *duty* of the physician to cooperate in the framework constructed for the prompt flow of justice in this State.

Our Committee strongly urges physicians to participate in the panels when called. Dereliction of duty is indeed a serious offense for one and all.

—**Russell A Quirk, MD,** Chairman
Medical Liability Committee
Physicians Alliance Division
State Medical Society of Wisconsin
Racine, Wisconsin

The Editors would like to encourage physicians to contribute to the LETTERS TO THE EDITOR section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Continuing medical education

The recent MEDIGRAM dated November 30 and received on December 10, 1979 with its enclosure is reminiscent of the scare tactics of Hitler during the second World War and of our own bureaucrats in recent years. If 1000 doctors were to stop practicing because they had lost their licenses, many Wisconsin residents would be without physicians.

Continuing medical education has been carried out since the days of Hippocrates and like motherhood is a good and necessary thing. In recent years the Instructional Courses organized by our Academy of Orthopaedic Surgeons and by many independent orthopaedic institutions have furnished almost unlimited opportunities for the orthopaedic surgeon to update his knowledge. I am sure that the same is true in your specialty and in all others.

My complaint is that the Federal, State, and subsidiary medical bureaucrats are taking over. Approved credits are now required by law before the doctor can renew his license. These credits may be obtained by taking a cruise, going on a

safari, or on a ski vacation. There must be kickbacks when travel bureaus, steamship companies, and airlines can get their "programs" approved when they have little, if any, value to a practicing physician. The commercialization of CME with the promotion of fantastically expensive tax-deductible vacations to earn brownie points has become a scandal if not an actual rip-off.

The circulation of lists of 1800 doctors who had not accumulated sufficient points to be relicensed and release of other information to the lay press were vindictive acts. They seem to have been implemented by Ms D Zychowski (Executive Secretary, State Medical Examining Board). I can well understand her desperation as evidenced in her interview.

The deadline reported was November 27. That is as inaccurate as the statements of the Federal bureaucrats about dishonest doctors. The records were much farther behind and incomplete.

The important thing is that you can't force a doctor to acquire knowledge. If he is so inclined, he can sleep through 30 hours of CME to rest up for the evening festivities and get full credit.

The only way to avoid complete chaos and arrive at an acceptable solution is to keep the organization and decision making in the hands of the sincere leaders of medical education. This must be done for each individual specialty including family practice after intensive study and planning.

In my specialty, these leaders are aware that we need not only offer education but proof that the members have acquired sufficient knowledge to qualify them to continue in practice. Re-certification as envisioned by the Federal bureaucrats would be a futile, costly mistake. Our American Board of Orthopaedic Surgery is working on a plan to maintain and evaluate continuing competence. I offer these excerpts from the tentative plan which is based upon the following three principles:

[1] That participation and especially learning in continuing medical education are important indices of the desire of the individual to maintain competence.

[2] That an examination can allow an individual to assess how well he has learned the material to which he or she has been exposed in continuing medical education.

[3] That specialization and different practice patterns demand variability of programs and plans for assessment of continuing competence. The Board has proposed three separate voluntary pathways by which an individual can be re-certified.

Pathway A is the principal one and it is anticipated that most orthopaedists will utilize this route. It involves the following steps: [1] Filing of an application form, especially designed to provide information regarding the applicant's professional activities. [2] Submission of a practice profile which consists of a listing of cases (seen either in the office or at the hospital) which allows the Board by computer technique (see below) to assess the type of practice that the individual has and modify the scoring of any examination which is taken. [3] Proof of attendance at three or more special "what's new" courses which include as part of their program, pre- and post-testing. It is important that these courses will be sponsored by all of the important orthopaedic societies. [4] Review of a Syllabus which would include a series of study questions. [5] Completion of either the Orthopaedic Intraining examination or the Orthopaedic Self Assessment Examination in the preceding two years. [6] Successful completion of a special self assessment examination given anonymously.

The old adage still holds that the men who need to learn don't come to lectures. The leaders of our specialty will see that many of them do. If the bureaucrats are permitted to try to force the delinquents to learn something, the doors will be open for more dishonest manipulation and paper work, paper work. Our medical leaders must fight to keep authority and then must continue to work to establish an acceptable program.

I think that the fiasco in the attempt at enforcement of the accumulation of CME points by the State Medical Society and the publicity in the *Milwaukee Journal* of December 12, 1979 merits some editorial comment. I have my new license so this is not "sour grapes."

—Walter P Blount, MD
Milwaukee, Wisconsin

EDITORIAL COMMENT: Doctor Blount's qualifications as a medical educator are well known around the world. But the system he proposes would require real effort on the part of physicians—perhaps more effort than many would be willing to expend.—WJB

Expanding role of mammography . . . continued

I would like to address some of the issues raised by Dr J L Hoehn *et al* (LETTERS, December 1979, *WMJ*) regarding my article, "Expanding Role of Mammography," published in the August 1979 *Wisconsin Medical Journal.*

The "dominant mass" that suggests a disease state may not always be clearly evident on inspection or palpation, particularly in early cancer. The mammogram is the most useful modality, which very often gives the physician that extra assurance that he may be dealing with a malignant or benign process. It is often the added bit of suspi-

cion that leads to prompt exploration. In the face of a definite lesion on clinical examination that is about to be explored, the mammogram can yield additional information about the rest of the breast or the opposite breast. A cancer that is completely nonpalpable may be lurking elsewhere in either breast, and that "other lesion" and not the palpable mass leading to exploration may be the cancer. It should be remembered that mammography can prove to be a particularly valuable diagnostic procedure to the average physician with average experience in breast palpation when confronted with a breast problem. A mammogram can be life-saving in avoiding delay, especially in the equivocal cases.

It is our impression that the consensus of opinion at the August 1978 Symposium on Breast Cancer published in *Surgical Clinics of North America,* felt that mammography plays a useful role in helping establish the management of the patient's condition prior to biopsy, since in experienced eyes there is over 90% positive correlation with biopsy. If mammography is interpreted as diagnostic or suggestive of cancer, the patient's preoperative evaluation should attempt to rule out disseminated disease (bone scan, skeletal survey, and other comparable means) before radical mastectomy is undertaken. If mammography was not suggestive of a malignant disease, only biopsy should be performed on the dominant mass. Then if the biopsy specimen is proved malignant, a similar search for metastasis, before undertaking radical mastectomy, should be done. By following these steps there is elimination of excessive diagnostic procedures in breast lumps which are most likely benign as well as radical mastectomies in those instances where disease has already metastasized.

Therefore, I am in full agreement that dominant breast masses must be either aspirated or biopsied, but only after utilizing the pertinent diagnostic procedures. This helps to insure that clinically occult cancers are not missed, contralateral breast cancers are detected, and malignant calcifications without tumor localized.

Regarding pneumocystography, in cases where the fluid is bloody during cyst aspiration or refills shortly after initial aspiration, a pneumocystogram should be performed. This procedure arms the surgeon with immediate diagnostic and localizing information of the patient's lesion preoperatively. A simple cyst puncture tells nothing about the interstitial area around or between cysts, whereas pneumocystography visualizes the entire breast as well as localizing problematic areas in and surrounding the cyst.

While benign processes such as papillomas and fibrocystic disease are the most common cause of nipple discharge, in patients over the age of 50, cancer becomes the most frequent cause. Both bloody and watery nipple discharges have a positive correlation with breast carcinoma, and should be evaluated with that in mind. Although galactography is not able to differentiate between very small papillomas and carcinomas, the procedure can demonstrate if the nipple discharge is caused by dysplasia far from the main ductal system and thereby avoid an unnecessary biopsy or repeat biopsies. Generally speaking, malignant lesions are situated further from the ductal system than benign lesions. Also in the case of papillomas, galactography localizes the affected duct minimizing the area for surgical excision.

With respect to Doctor Hoehn's concern of radiologists "needling surgical patients and penetrating pectoral facia and muscle," I have performed over 100 needle localizations and specimen radiography without any subsequent complications. Selection of correct needle length and approach should be a matter of common sense and a reasonable amount of medical training.

When discriminately applied, mammography, galactography, breast ultrasound, and pneumocystography are extremely valuable diagnostic tools, since they make possible the discovery of occult carcinomas of the breast. Considering that a large amount of occult carcinomas has proved to be in the early stages, we rightly expect that the chances for a ten-year survival of these patients can be greatly improved by using these methods. According to Jerry Urban at the American Cancer Society's 1979 National Conference on Breast Cancer, there is a 97% ten-year survival in those minimal breast cancers treated by modified radical mastectomy without adjuvant chemotherapy.

These roentgenologic methods in the examination of the breast are valuable if there is close cooperation and teamwork among clinicians, radiologists, and pathologists. Correctly performed and interpreted, these diagnostic examinations help to establish a correct as well as an earlier diagnosis than is possible with methods traditionally used.

We now have some very effective methods of cancer treatment and cure for certain types of cancer, but they are curative primarily for cancer treated in the early phases of growth. Since there are no diagnostic procedures or techniques with 100% accuracy, we must exhaust all diagnostic modalities available to us in order to enhance the rate of early detection and therefore possible cure.

—**Raul H Matallana, MD,** Director
Division of Oncologic Diagnostic Radiology
University of Wisconsin Clinical Science Center
Madison, Wisconsin

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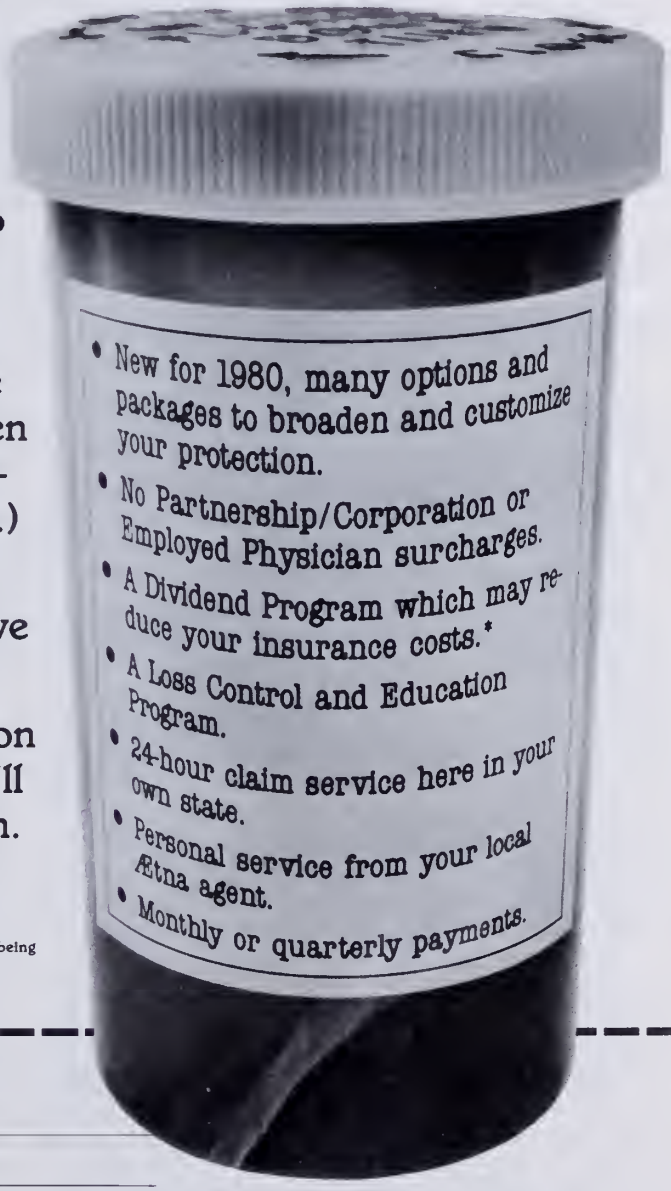

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In Perspective

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

Who's kidding whom . . . ?

BRIAN H JENSEN, Madison, Wisconsin

As might be expected, a variety of editorial writers for state papers recently rushed to the presses to decry the rejection of the Carter administration's hospital cost containment bill by the House of Representatives. That action, according to the self-appointed experts on healthcare that seem to reside in these editorial offices, was due, *of course,* to the heavy-handed lobbying of the AMA and the American Hospital Association and their companion political action committees. *Of course,* the Congress simply did not have the courage to face up to the issue of rising health care costs because of an unwillingness to offend hospital and healthcare providers with an election season only a few months away. *Of course,* "special interest" groups have a strangle-hold on Congress at the expense of the consumer-taxpayer.

Such commentators conveniently ignore the fact that unlike many segments of the economy, the healthcare industry has managed to come within a few percentage points of meeting its goal of cost containment via the much maligned "voluntary effort." For most of calendar 1979 physician fees trailed most other components of the Consumer Price Index. Third-party payors of healthcare services have restricted reimbursement severely in the past 24 months, in some cases to less than half of the overall rate of inflation. Surveys of physician fee increases reflect a general commitment to small adjustments far below what the advocates of the healthcare crisis would have us believe is the norm in the industry.

It would not be hard to offer reasons for the defeat of the cost containment proposal; extracts from the rhetoric within the pages of the *Congressional Record* could easily be repeated here. However, intuition suggests a far simpler reason—the political "buzzwords" of cost containment and national health insurance just have not caught the expected attention of the American taxpayer. No great outpouring of citizen demand for these proposals has occurred except for the self-annointed consumer representatives hard pressed to identify a broad-based clientel. (A phenomenon existing not only at the federal level; Wisconsin has its share of such self-proclaimed protectors of the masses.)

The simple fact is that the Carter administration proposals for cost containment and the Kennedy "Health Care for All Americans Act" are not catching on with the public. The reasons may be complex from the standpoint of sociological analysis. Perhaps Jerry Brown's "Politics of Lower Expectations" *is* catching on with the public in spite of his less than enthusiastic standing in the polls. Perhaps the country is becoming more suspicious . . . and conservative. Or, perhaps people just don't care.

I tend to believe that the public is too overwhelmed by the rhetoric and the fear of the unknown. While the *Wall Street Journal* does not have the exposure that state dailies enjoy with the Wisconsin citizenry, *one* issue—the December 18, 1979 edition—contains two indepth articles that seem to illustrate this point. One is an analysis of the economics of the 1970s versus the 1960s entitled the "Sputtering '70s." The other is the second installment of a series on the state of Congress called the "Inert Body."

The *Journal's* economic analysis characterizes the '70s as a sputtering period of economic change with growth evident, but with "disturbing changes ahead." While the growth of jobs in the '70s increased by 25% compared to 18% in the '60s, productivity in the '70s fell and prices rose. All consumer prices rose in the '70s by 94% compared to 24% in the '60s. Food prices alone grew 107% in this decade compared to 24% ten years ago. Some individual price categories rose by epidemic proportions—a new home in 1970, for example, had an average price of $26,600. Today that price approaches over $72,000! A constant 9% increase in the CPI means that the value of the dollar is cut in half every eight years.

Mr. Jensen is Director, Physicians Alliance Division of the State Medical Society of Wisconsin. Copyright 1980 by the State Medical Society of Wisconsin.

Other analysts have stated that a dollar's worth of healthcare in 1967 today costs $2.21. But the 1967 dollar for auto repairs is today requiring $2.24; housing is $2.67; mailing a first class letter is $2.57!

Unfortunately, the public feels helpless in attempts to check this growth and that helplessness is reflected in public apathy towards healthcare costs—cost increases not different than those attributable to food, shelter, clothing, and services. Yet healthcare costs are inappropriately singled out for regulation and containment. And singled out in a time when statistics demonstrate that healthcare today is better than it was in 1970, or 1965, or 1960. But has the *quality* of food, housing, or services increased as dramatically? Methinks not. Unfortunately, not *one* of the congressional proposals for altering the economics of healthcare even mentions *quality*, only quantity and cost.

From the economic side, therefore, we are faced with a situation of helplessness, frustration, and a public resignation that little can be done.

The traditional source for relief since the days of the New Deal has been government, in particular the Congress. Yet, the "Inert Body" characterizes Congress as a bureaucracy unable to effectively deal with any substantial policy question. The US Senate today averages 68 staff members per senator. The last ten years have seen a 270% increase in staff payrolls; a fact which earned Congress the August 1979 "Golden Fleece" Award from our own Senator Proxmire. The House of Representatives has similar problems. Its 435 members sit on 168 different standing committees and subcommittees—a situation which has resulted in the computer-confirmed fact that in 1977-78 there were 11,000 occasions when any single House member was expected to attend two or more committee meetings!

In order to study and resolve this fragmentation of the legislative process, the House created (you guessed it) a "Committee on Committees."

What's the relationship between health politics, the economy, and Congress? Simply put, Congress seems unable to solve any significant problem, especially one relative to the economy because of its own weight and inertia. The result is a reliance on emotionalism and rhetoric, which is exactly what happened with the hospital cost containment bill and what I suspect will happen with national health insurance. That sets the stage for the editorial writers to pick up the banner and advise the public of their losses.

Whether its your congressman, your senator, or your local editor, who's kidding whom? ■

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Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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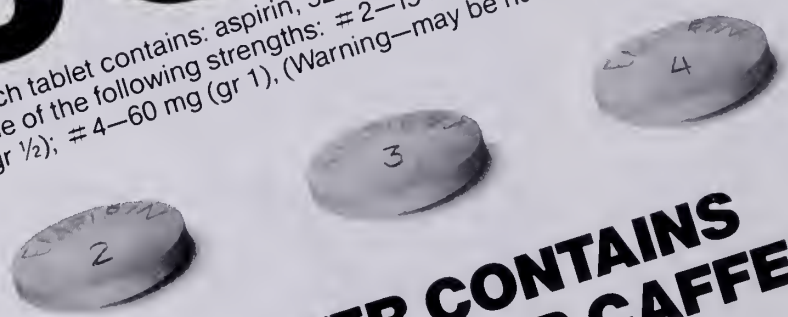

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Evaluation of the patient with a positive Hemoccult® test

THE GUAIAC TEST for occult blood in the stool has been in use since 1864.[1] Modern packaging has simplified the procedure with the Hemoccult® II Kit (Smith Kline Diagnostics, Sunnyvale, CA 94008). Segments of the population may now be approached with low cost screening projects in search of premalignant or asymptomatic malignant lesions of the colon and rectum. There is a widely held axiom that proper management of occult lesions will yield improved salvage of humans. In the United States, the colon and rectum are the most frequently afflicted with cancer, except for skin. This is of interest in terms of cancer control. Although the potential improvement is real, cost:benefit relationships are being examined carefully. The Consensus Development Conference held June 26-28, 1978, by the National Cancer Institute did not support uncontrolled mass screening programs[2] at that time. To a great extent this had to do with large scale cost:benefit ratios and did not relate to individuals with occult cancer.

A patient who shows presence of occult blood on screening may produce a puzzle for the physician in terms of further evaluation. Based on prior[3] and current[4,5] evaluations of screening, we have developed an orderly sequence of studies to maximize diagnostic yield and minimize expense and distress.

Such an evaluation must start with specific inquiry and careful physical assessment of the patient. The physician should obtain a personal history of gastrointestinal disease (peptic ulcer, inflammatory bowel disease, and the like); inquire about rectal bleeding (melena, hematochezia, hemorrhoids); evaluate other bleeding (nosebleed, dental extraction or cleaning, menstruation during the test period); and record drug use (aspirin or other antiinflammatory drugs, anticoagulants), family history of colorectal neoplasms, bowel habits, and abdominal pain.

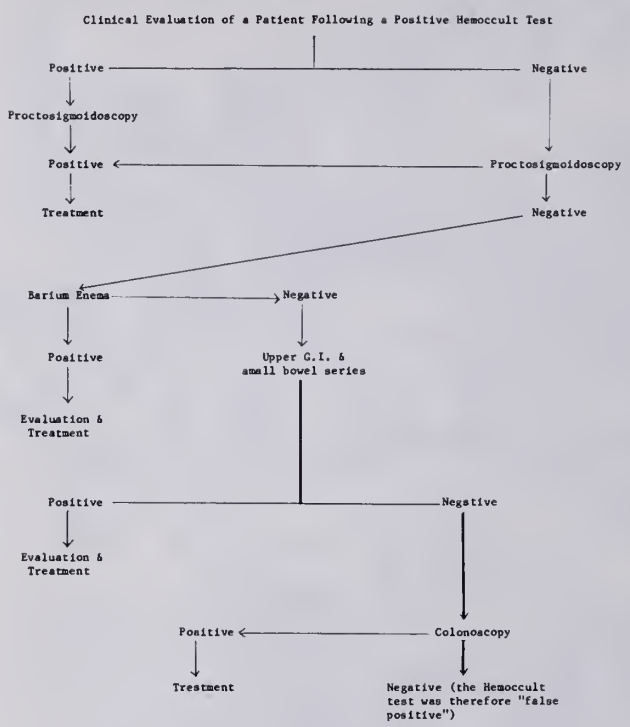
The instructions accompanying the Hemoccult® testing kit warn patients not to test their stools while menstruating or taking aspirin (which may cause false positive reactions), when taking vitamin C (which may cause false negative reactions), or if rectal bleeding is seen. Frequently patients don't comply with these instructions, so Hemoccult® testing should be repeated in the proper manner.* If gross bleeding has been observed, other forms of evaluation are indicated. Those with a parent or sibling with colorectal cancer are at special risk and should be evaluated regularly.[6]

Evaluation of a patient with a positive Hemoccult® test should continue with an examination of the abdomen and rectum, repeating the Hemoccult® tests if stool can be obtained, and performing other tests as indicated:

Finding occult blood in the stool is not uncommon. In our studies 3-6% of those screened have positive Hemoccult® tests. Other authors' findings are also in this range.[7,8] Neoplasms may account for positive tests in less than one-half of these patients. However, those with an unexplained positive Hemoccult® test should not be dismissed but deserve careful evaluation and competent counseling. Denial of the importance of the test may be worse for the patient than not doing the test at all, since subsequent frank bleeding or other symptoms may then be dis-

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1979 by the State Medical Society of Wisconsin.

* Often a meat-free, high-fiber diet starting 48 hours before making the first Hemoccult® slide is suggested to the patient.



missed by the patient. A small number of people will have no bleeding site identified ("false positive"). These people deserve careful followup and study. There is no data at present to indicate the best method. We recommend repeating Hemoccult® testing every three months for a year.

(References cited in the text are available on request from Dorothy J Buchanan-Davidson, Wisconsin Clinical Cancer Center, 600 Highland Ave, Madison, Wis 53792.)

—**Robert H Greenlaw, MD**
Radiation Oncology Section, Department of Clinical Oncology, Marshfield Clinic, Marshfield, Wisconsin
and
—**Robert G Norfleet, MD**
GI Section, Department of Medicine, Marshfield Clinic, Marshfield, Wisconsin ■

Carcinogens in our environment—how much risk?

Summary of talk given at Midwest Cancer Seminar, September 20-22, 1979, Madison, Wisconsin

Even though estimates which state that 80% to 90% of all human cancers are induced by environmental factors may be in error, the number of environmentally induced human cancers is probably significant; and prevention of such cancers could dramatically decrease human morbidity and mortality from cancer.

Since it is impossible to study carcinogenesis in people directly, the relationship between studies using lower forms of life and humans is important. Epidemiological methods of studying carcinogenicity are difficult since there is a long lag period between exposure and the clinical occurrence of a neoplasm. Many of these studies are inconclusive in indicating risk factors. The cummulative dose required per kg body weight for tumor induction in humans and experimental animals is of the same order of magnitude in some instances.

The metabolic pathways in humans are similar, if not identical to those in lower animals, but differences in the rates of various reactions between experimental animals and humans should be expected. Conclusions reached in any biological or chemical analysis must rest on some basis or standard. The mere production of a neoplasm in an experimental animal tells little of the molecular and biological processes preceding the appearance of the neoplasm. Bioassay data obtained from animal studies should be interpreted in light of knowledge about the natural history of the neoplasms produced and not solely on the basis of statistical considerations. Initiating agents can be chemical, physical, or biological and are capable of directly altering the molecular structure of the cell DNA. A promoting agent alters the expression of the genetic information of the cell or can significantly decrease the time between application of the initiating agent and appearance of the neoplasm. Promoting agents exert effects which can be modified by the environment.

It is impossible financially and physically to test all compounds in animals, so bioassays are used. No single screening procedure can definitely identify a compound which should be tested in animals, so a battery of screening procedures is used. For animal bioassays to be useful, an estimation of carcinogenic potency and knowledge of the dose-response relationship is needed, since carcinogens vary in potency by over a millionfold and there are species differences.

There appears to be a direct relationship between whole animal bioassay data and carcinogenic potential in humans. A few agents are carcinogenic in animals but not in humans and vice versa. In extrapolating bioassay data to estimate human risk, several factors must be considered: potency of the agent as determined by human and experimental assays, the nature and quantity of exposure to humans by the agent, and individual susceptibility of humans to the agent.

The determination of human risk based on bioassay data is an extremely difficult process which presently rests on very flimsy scientific grounds. Risk estimation must be determined on scientific data as well as social and political pressures. ■

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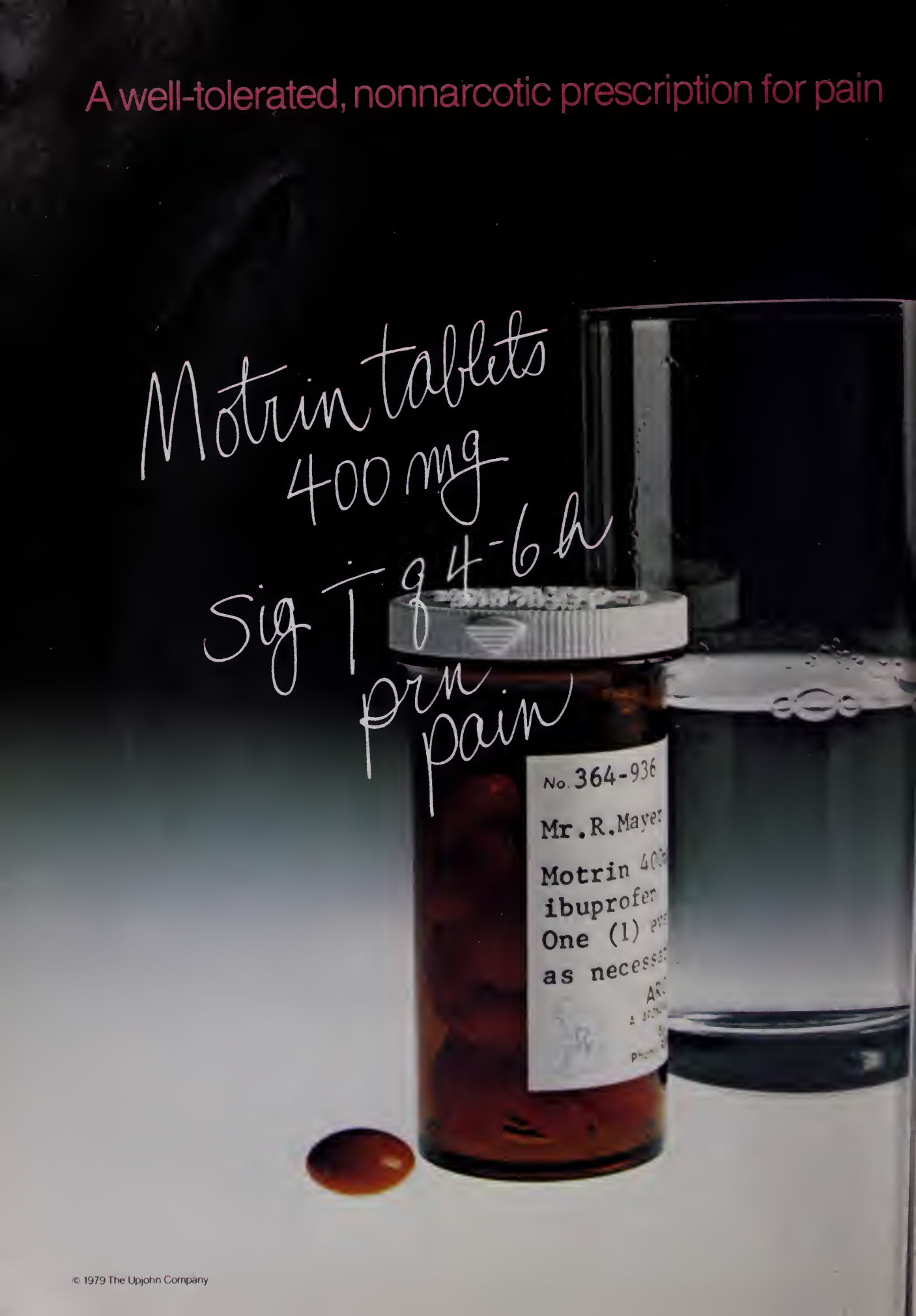
A well-tolerated, nonnarcotic prescription for pain



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Motrin® now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400 mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

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From here to eternity...the development of the "Super-Rule"

Brian H Jensen, Madison, Wisconsin

With humble apologies to James Jones, this paper is an attempt to summarize the development of the "Super-Rule"; the first effort by the State Department of Health and Social Services and the Wisconsin Legislature to codify the rules of the Wisconsin Medical Assistance Program (WMAP).

Like the Jones epic novel, this process has been a long, trying experience with a corresponding "cast of thousands." Since early 1976, the State Medical Society's Physicians Alliance has been actively involved in representing physician concerns with the construction of this rule. So massive was the research, so detailed was the work, and so intensive was the negotiation that for the first time in the history of the program nearly all provider organizations and associations banded together to form the Health Care Coalition. This body served to present a cohesive and united front in working with the Department of Health and Social Services (DHSS) and the legislative committees responsible for oversight into the rule development. Because so many of the provisions of the rule were uniform in their application to the various providers, this Coalition worked with DHSS to resolve these sections of the rule. Fortunately for all concerned, the Department under both Donald Percy, Secretary of the agency, and Robert Durkin, Administrator of the Division of Health, openly and willingly conferred with the Coalition. For that we are all thankful.

This paper will present the rule and the process of its development in four parts: the financial aspects of the WMAP which led to the development of the rule; the "provider agreement" and its relationship to the rule; the rule itself and the provisions which directly relate to physicians (including a comparison of the final draft vis a vis the original draft by DHSS); and finally, a discussion of physician reimbursement in the WMAP and what the future may hold for alterations in that reimbursement methodology.

Mr Jensen is Director, Physicians Alliance Division of the State Medical Society of Wisconsin. Copyright 1980 by the State Medical Society of Wisconsin.

THE WMAP BUDGET

While the Medical Assistance Program was created by the United States Congress in the mid-1960s, it was not until three years ago that the Wisconsin Legislature requested that the DHSS codify into a single document the "rules" of the program, be they state regulations already in existence, federal statutory requirements, unwritten policies of the program as exemplified by the processing of claims by the fiscal intermediary, or policies developed by the agency.

Medicaid is one of many federal programs that require the use of "matching" state funds to supplement the financial commitment from the federal government. Over the years that cost sharing has fluctuated but roughly corresponds to a 60% federal - 40% state sharing formula. Both "shares" are paid through the use of what budget analysts call general purpose revenues; *ie,* regular income tax dollars. Simply speaking, the Medicaid program is funded through taxes paid to both the state and federal governments. The budgets for Medicaid, at least in Wisconsin, have traditionally been "sum sufficient;" that is, an amount appropriated each biennium by the Legislature necessary to pay the costs of the program. The cynics among us call such appropriations "blank checks," and in effect they are, although there is significant pressure from the Joint Committee on Finance of the Legislature to the DHSS to live within the limits of a projected expenditure every two years. As we will see shortly, it was this potential for significant cost overruns in the 1979-80 biennium which led to a serious review of the program by the Legislature during its consideration of Governor Dreyfus' proposed 79-80 budget early in 1979.

If for no other reason, it was the budget for Medicaid over the past few years that demanded the development of the rule. Only nine years ago, the biennial appropriation for Medicaid was slightly more than $100 million. A significant decision for the Legislature that year was the passage of the first billion dollar GPR budget. By 1979, the state budget was in the neighborhood of $12 billion, with the

Medicaid budget alone approaching $1 billion for the two-year period. Figure 1 summarizes the GPR growth of the Medicaid program from the fiscal years of 1973 to the present. As you can see, the financial commitment by Wisconsin has been significant. Since 1966-67, the first year of Medicaid, the growth in cost has exceeded an 875% increase.

The most obvious question is "Why?" Because Medicaid operates on a sum sufficient budget, money is appropriated to meet the financial needs of the program. Those needs have increased drastically for several reasons. First, the *benefits* of the WMAP are among the best in the nation. The federal government requires a series of ten basic core services which must be provided. In addition, individual states may select a series of optional services (a total of ten) which may be provided if the State Legislature decides to "match" the federal financial contribution. In Wisconsin *every* optional service has been approved with the result being that the Wisconsin program is one of the most comprehensive healthcare programs in the nation. The ten mandated services range from inpatient hospitalization and skilled nursing facilities to transportation and rural health clinics. One of the optional services, intermediate nursing care, constitutes slightly more than 30% of the total program expenditures. Other optional services approved by the Legislature include drugs, dental, podiatry, non-MD vision care, and chiropractic. Only four states offer *all* optional services — Illinois, Washington, Minnesota, and Wisconsin. Secondly, *utilization* of those benefits has skyrocketed through the numbers of individuals who are recipients. Nearly 7.5% of the state's population (338,000 persons by 1979) is covered by the WMAP. Third, *inflation* has had a dramatic impact on the cost of providing the many services available in the program. Inflation brings us to the fourth major reason, which is the *reimbursement mechanism* utilized for some services. The two major recipients of the Title 19 provider dollar are hospitals and nursing homes. These two entities constitute approximately 69% of the annual provider reimbursement dollar. Payments are made through the use of statutory formulas which are based upon a factor of the documented daily costs in the facility; that is, a "cost" basis rather than a predetermined reimbursement schedule which may fail to take actual cost into account. In spite of these cost-related formulas, many institutions are suffering from the inflationary impact of the program. This has led to some institutions refusing to participate in the WMAP.

Three provider groups in Wisconsin constitute 75% of the MA expenditures — hospitals, nursing homes, and physicians. Figure 2 summarizes the growth in reimbursement to three provider types over the last five fiscal years. While total physician reimbursement has doubled since 1973 ($16 million to $32 million), it is drastically exceeded by the top two providers. This is due in large part to utilization, coverage, inflation, and most importantly, the reimbursement methodology.

When examining these four factors, it is important to keep in mind that regardless of the factors, the Wisconsin Legislature has made the decision, conscious or not, to provide the full range of benefits. Whether that decision is part of the Wisconsin progressive tradition, whether the Legislature was unaware of the impact of the inclusion of these varied benefits, or whether the Legislature simply responded to the demands of recipients *and* providers for the inclusion of the benefits depends a great deal upon one's personal political perspective.

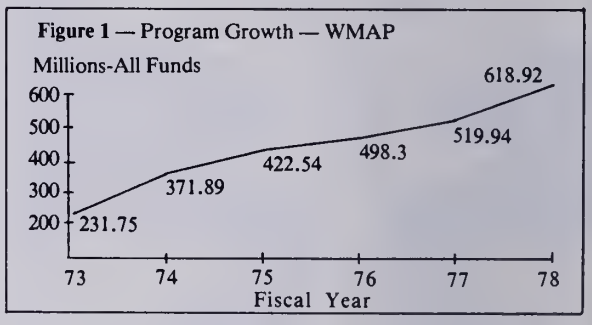


Figure 1 — Program Growth — WMAP

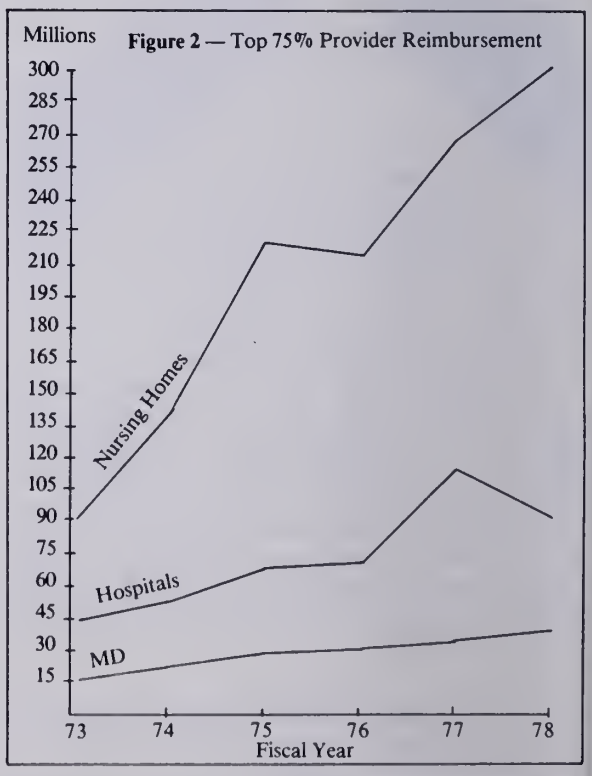


Figure 2 — Top 75% Provider Reimbursement

The simple truth is that it *has* happened and now the State of Wisconsin is faced with the difficult question of how to contain costs in the future.

A recent study by the Wisconsin Taxpayers Alliance, a nonpartisan, nonprofit citizen research group, identified Wisconsin as having the fourth highest per capita commitment to Medicaid, totaling $101 per person for 1977. This is 28% higher than the national average of $79. Only three states exceed Wisconsin in this respect — New York, Massachusetts, and Rhode Island. Of the 49 states that have a Medicaid program (Arizona being the sole state without a program), Wisconsin ranks tenth in average payments per recipient. The total United States expenditures for fiscal year 1977 are summarized in Figure 3. As you can see, a significant amount of the total is expended in but a few states, with ten states (including Wisconsin) constituting 66.2% of the total national costs.

Only recently, DHSS Secretary Don Percy indicated that a variety of techniques will be used in the upcoming second year of the 1979-81 biennium to prevent major cuts in the program. The Secretary indicated that approximately $3.5 million in state funds for DHSS would be cut in a proposal to be sent to Governor Dreyfus in early 1980. The Department predicts only a 2% overall increase in Medicaid for fiscal 1980-81. That 2% increase actually will cost the state taxpayers an additional $12 million, but changes in other areas of the massive budget of the Department will be used to reduce that increase to the $3.5 million figure. The total biennial costs for WMAP is about $1.2 billion, 40% of which is paid directly by state tax dollars. However, the unknown factor of inflation may possibly affect these changes in that the Legislature, in approving the budget earlier this year, assumed a 7.5% inflation rate; a rate now more realistically approaching 12%.

Of this $1.2 billion program, how is the money spent? Figure 4 represents the WMAP expenditures for fiscal year 1978. Hospitals and nursing homes receive approximately 69 cents of every dollar in terms of payments to providers. Physicians in 1978 received only six cents of every dollar. As the pie chart indicates, 4.5% of the program dollar is spent on the administration of the program. Even though this amount approaches the total payments made to some providers, this amount is the *lowest* spent by the 49 state agencies with a MA program.

THE SUPER-RULE CONCEPT

Why a "super" rule? Any program which requires the expenditure of $1.2 billion would seem to suggest the need for "written rules of the road." While it may seem unbelievable, until this rule the State of Wisconsin was spending nearly a billion dollars every

Figure 3 — Total Medicaid vendor payments by size of state programs, fiscal year 1977

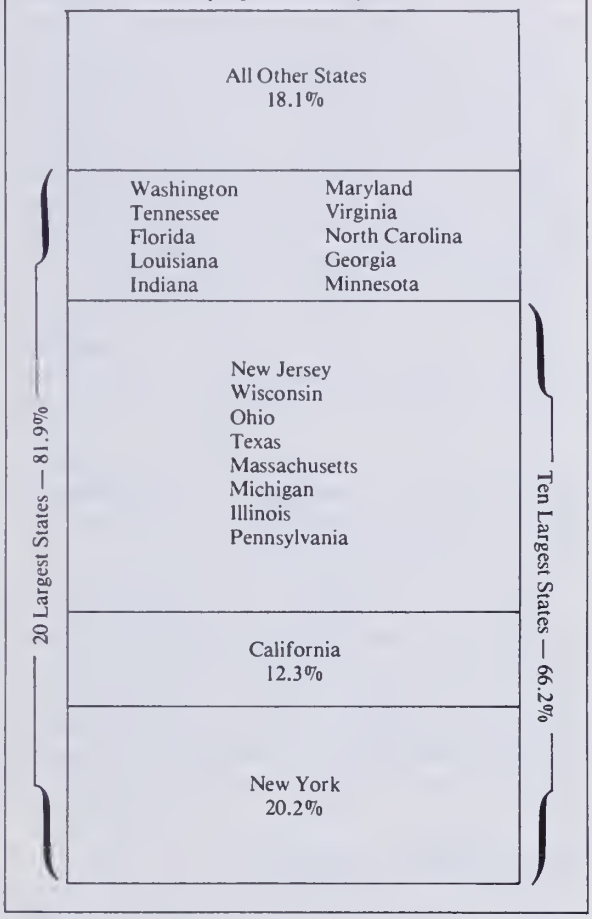
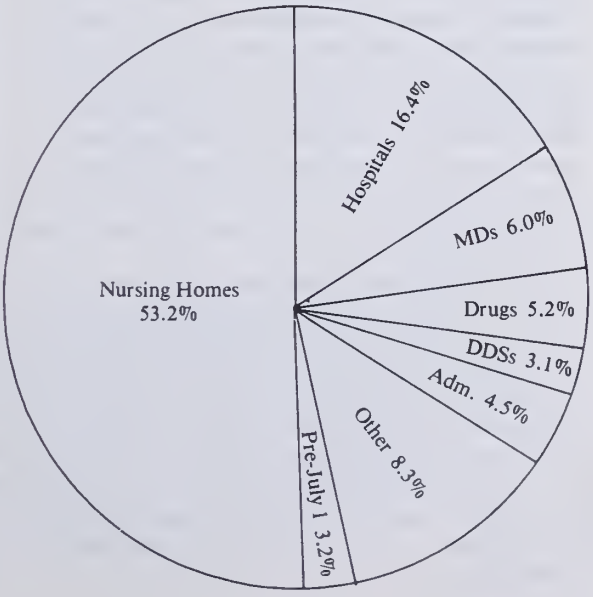


Figure 4 — The 1978 T-19 Dollar



two years in a program that *did not* have a set of standards in one area of the Wisconsin Administrative Code. When the Physicians Alliance began to research indepth the Medicaid program in early 1976, it was unable to discover any guarantees for the protection of provider rights, unable to determine the right of providers to procedurally challenge decisions by the program regarding certification, reimbursement, or termination from the program, unable to obtain written Department procedures for prior authorization, insuring recipient eligibility, or challenging the reimbursement methodology.

Regardless of whether physicians philosophically prefer the development and use of a "super-rule," it does provide, for the first time in the 13-year history of the program, a single source of information regarding these and hundreds of other previously unanswered questions. What program in private enterprise would allow the expenditure of over $1 billion *without* rules and guidelines? The WMAP is no exception . . . any longer.

After February 1, 1980 the rule will be the "law of the land" in the WMAP. It will stand as a valuable resource document for providers and recipients alike as to what is permissible and what is not allowed in the program. And as we shall see shortly, it provides a tremendous amount of protection to physicians not previously delineated in the general policy statements issued by the Department in the past.

THE PROVIDER AGREEMENT

Before examining the specifics of the rule, however, it is necessary to understand the relationship between the rule and the "provider agreement."

Last summer, the Department issued the now infamous Title 19 "contract." That document was, in effect, an interim "super-rule" in that it attempted to outline some of the elements of the program essential to its operation. It was far from a perfect document and, in fact, resulted in a general "fear of the unknown" for many providers, physicians included. Ironically, many of its provisions were unwritten policy of the Department for years; physicians and others were simply unaware of that fact due to the absence of formal administrative rules and regulations.

The new "provider agreement" replaces the 1978 contract. It is, in effect, a replacement for what once was a federally-required statement appearing at the bottom of every Title 19 claim form. When that language was removed from the claim form and recreated into the 1978 "contract," additional provisions were added that previously were reflected in general departmental policy. That expansion served to provide the first written confirmation of those policies . . . and also significant physician dissatisfaction.

Prior to the effectiveness of the "Super-Rule," every physician (and other providers) currently participating in the program will receive the 1980 version of the "contract" — now called the provider "agreement." That document is very brief . . . only a single page . . . and contains but two provisions:

(1) that the physician certified in the program agrees to abide by the rules of the program when providing care to recipients, and

(2) that the physician agrees to accept payment for services rendered according to the methodology attached to the agreement as payment in full for the services.

Neither of these provisions is new; both have been required of physicians (and other noninstitutional providers) since the inception of the program. This agreement is effective for *one year,* and is automatically renewed every year unless either party — the physician or the Department — chooses not to renew. Either party may "opt out" of the program on a 30-day notice. Physicians may leave the program for any reason. The Department must follow a detailed procedure in order to "involuntarily terminate" a provider, including an opportunity for hearings and the provision of due process rights under Chapter 227 of the Wisconsin Statutes — the general administrative procedures act of state law.

This agreement will be distributed to physicians shortly after January 1, 1980 and will have been received by the time this paper appears in print. The agreement should be signed and returned to the Department as soon as possible. Because the rule includes a retroactive certification provision, the absolute deadline for submission of the agreement is March 31, 1980 if physicians wish to have claims paid for services rendered after April 1, 1980. Of course, any physician can become an authorized provider at any time, although claims will be paid retroactively only 30 days.

In October 1979 the Physicians Alliance Commission of the State Medical Society formally endorsed the format and content of the agreement as acceptable and a suitable replacement for the 1978 provider "contract."

When a physician who is *not* currently in the program decides to participate, additional forms must be completed. An *application for certification* and a *Title XIX profile* (*not* the T-18 payment profile) must also be completed. In the near future the Department will be revising these forms in order to combine them into a two-page form rather than the four- to five-page format used in the past. Physicians *currently* certified in the program will *not* be required to file these additional forms, only *"new"* providers — those currently not participating in the WMAP.

THE SUPER-RULE DEVELOPMENT PROCESS

When it is finally published and effective, the "Super-Rule" will become part of the Wisconsin Administrative Code. It will have the force of law equal to laws published in the Wisconsin Statutes. For example, the Motor Vehicle Code is also part of this administrative code system. Any violation of the codes in the rule may result in either termination or penalty or both.

The "Super-Rule" was developed and promulgated under a rule process which is different from that currently in effect in Wisconsin. As part of the biennial budget, the Legislature revised that system to provide greater legislative oversight and prior approval of future administrative rules. Governor Dreyfus, like all governors before him, vetoed that part of the budget bill. Those vetoed sections were eventually overridden by the Legislature and stand now as law in the state.

The major effect of these changes is the fact that now the standing committees of the Legislature have the statutory authority for review — and approval or denial — of rules prior to their effectiveness. This process is important in the Medicaid program in that future revisions to the "Super-Rule" must use this process of legislative review. It provides greater opportunity for citizens and organizations to affect the development and ultimate future of rules. In addition, any major revisions to this rule require consultation with the affected provider groups and the reissuance of the provider agreement — regardless of the time of the existing agreement year — is required whenever the reimbursement methodology is significantly altered.

The rule has traveled through a three-year path towards promulgation with several rounds of departmental hearings, legislative hearings, and alterations by the Governor via the budgetary process. The Physicians Alliance and the Health Care Coalition have had many opportunities to express the views of organized medicine and all providers respectively. Those opportunities have resulted in the development of a rule which now protects providers as well as imposing rules and regulations.

THE SUPER-RULE PROVISIONS REGARDING PHYSICIANS

The provisions of the "Super-Rule" run in excess of 300 pages. About 30 pages of the rule relate to physicians' services including the section on Mental Health. The rule includes chapters on provider certification and general procedures which apply to all noninstitutional provisions. This section outlines several of the key provisions of the rule; provisions which have been debated at great length through their development and which are significantly different from the initial draft *or* past Department policy.

Before summarizing these provisions, however, it is important to note what this rule *does not* do with respect to physicians' services and participation.

This rule does not:

1. ***Tell you as a physician how to practice medicine.*** The rule is a codification of procedural rights, responsibilities, and policies for both providers and recipients. While it does contain lists of physician services which are not reimbursable in the WMAP, those services are not paid because of state or federal statutory law. The rule defines physician services as those which are deemed to be "medically necessary." Some services require prior authorization; *eg,* amphetamines, weight reduction, services provided out-of-state, etc. Other types of services are prohibited or, as in the case of abortion, are currently being contested in court. Physicians have the ability to make private arrangements with recipients for services which either federal dollars are not available or which are not covered at all. If you as a physician deem a particular service as necessary for the patient's health and that service is not reimbursable by the WMAP, you should so advise the patient and make private financial arrangements prior to the service. The rule only prohibits you from seeking payment from a recipient when that service is reimbursed by the program.

An appreciation. I am compelled to take this opportunity to thank the members of the Physicians Alliance Commission and the Council of the State Medical Society of Wisconsin for their commitment to a fair and proper resolution of this three-year project. Also invaluable were the technical skills of Alliance staff members Rick Reas and Marge May; the patience and support of the field consultants Lois Riley, Ken Opin, Calvin Dexter, Paul Jacobson, and Marv Stromer; and the dedication of Mary Howards and Kristine Wedeward to work through numerous drafts of testimony, T-19 updates, and "Super-Rule" presentations. And finally, to SMS Secretary Earl Thayer, whose historical perspective and advice were critical and whose commitment to medicine is without parallel. —BHJ

2. ***Require you to treat any or all recipients.*** Physicians are able to select their patients in WMAP just as they may in any other aspect of their practice. The rule/agreement only requires that you not discriminate against any class of patients because of race, color, creed, national origin, or physical/mental handicap alone. This is required by the Civil Rights Act, as amended, of 1964 and is applicable to all providers of any health service regardless of reimbursement source. You may limit your Title 19 caseload in any fashion or refuse service to any recipient as long as the Civil Rights Act is not violated; *eg,* you may terminate services to a recipient because of abuse, missed appointments, etc.

3. ***Bind you as a provider to future policies.*** Execution of the new provider agreement means you accept the regulations as currently outlined in the rule. Because the rule requires major policy changes to be implemented via the new administrative rules process, affected providers must have an opportunity to comment on proposed changes and must be notified of actual changes. At that point any physician may leave the program on written notice to the Department.

4. ***Change the reimbursement system for physicians.*** The reimbursement methodology for physician services in the program is based upon the use of Title 18 (Medicare) profiles. This system reflects the maximum reimbursement levels permitted by *federal* law. This maximum level was implemented after the successful lawsuit by the Alliance/State Medical Society against the Lucey Fee Freeze of December 1974.

5. ***Restrict the development of future policy in DHSS.*** Because the rule is part of the Wisconsin Administrative Code, changes to it in the future require public hearings and legislative approval or denial. This is a *major* change in Wisconsin law and permits numerous opportunities for physician input into the development of future amendments.

Throughout the rule process, a number of provisions of the rule were quickly identified as being of major concern to physicians. What follows is a summary of the changes in these provisions which the Alliance feels are beneficial alterations, as well as a few new aspects of the WMAP.

1. ***Medical Records:*** Several years ago both state and federal laws were amended to delete the T-19 recipients' right of privileged communication between physicians and recipients. The rationale for this change was that the use of public funds for this treatment required the ability of state agencies administering the program to confirm the delivery of claimed services. In actuality, this provision is not unlike most private insurance policies which give the carrier the right to review records for service confirmation, reimbursement, and quality of care. Many of these "waivers" for inspection of records by carriers are a condition of sale of the policy. This waiver by potential T-19 recipients is a condition of recipient eligibility. Prior to this change, only Aid to Families with Dependent Children (AFDC) recipients were required to grant such authority as a *condition* of eligibility. The rule allows HEW and DHSS employees to inspect such records. However, persons conducting such reviews must be authorized in writing by the Secretary of DHSS, may only review T-19 records, and may not physically remove records from a physician's office. Copies must be provided when requested, but at Department expense. *Under no circumstances* should any physician release non-Title 19 records, daily charge books, appointment books, etc to these Department employees. Physicians have the right to be present at the time of the inspection, or someone from their staff, and must be given reasonable notice of the inspection.

2. ***Consultations:*** The original rule would have prohibited reimbursement for any and all consultations by a second physician. Consultations are now permitted if they are documented and become part of the recipient's permanent medical record. An examination of the recipient is required and the name of the attending physician must appear on the claim form submitted by the consultant. In addition, other sections of the rule which proposed to ban all consultations by psychiatrists have been interpreted by DHSS to be inconsistent with this general consultation section for all physicians and, therefore, is not applicable.

3. ***Provider Appeals:*** Prior to this rule physicians had no recourse to the decisions of DHSS which were based upon unwritten policy or rules not a part of the Administrative Code. Because of the creation of the rule, any physician adversely affected by a Department decision may now appeal that decision according to Chapter 227 of the Wisconsin Statutes. That chapter provides due process to the physician and permits a hearing before an independent hearing examiner. If, at the conclusion of this hearing process the physician

is not satisfied with the decision, there is immediate appeal and access to the circuit court of Dane County.

This provision alone is a major and significant safeguard for physicians relative to departmental decisions.

4. ***Emergency Services:*** Early drafts of the rule would have required physicians to sign contracts before any reimbursement would be allowed. The final language allows a nonparticipating physician to provide emergency care and allows for billing the program through the use of special claim forms. The physician must attest that the condition of the recipient was a true emergency in the judgment of the physician. Provider agreements need not be completed in these cases. This exception does not apply to staffing provided in the emergency room of a hospital. In these cases either the physician or the facility must be a certified provider. Which provider — the hospital or the physician — bills the program depends upon the arrangement that the physician has with the hospital. If the facility bills the WMAP, it is directly reimbursed and not the staff physician.

5. ***Involuntary Termination:*** The rule contains a host of conditions under which a physician may be removed from the program for up to five years; *ie,* fraud, concealment, filing for services not provided, etc. The original rule would have barred from participation for five years anyone else connected with the "guilty" physician including partners, business managers, etc. This language has been amended to require that these individuals must have participated in or knowingly concealed the inappropriate activity (fraud, etc) of the guilty physician.

6. ***Prior Authorization:*** As in past departmental policy, a number of physician services require prior authorization from the Department. Unfortunately, in the past, nonphysicians (DHSS staff or consultants) were reviewing these requests and the corresponding medical judgment of the physician. The rule now requires DHSS to insure that the consultant in the Department conducting reviews possesses the same minimum training requirements as the person requesting authorization. Hence, physicians review physicians' requests and not nurses, social workers, etc.

7. ***The Primary Provider Program:*** The rule permits DHSS to assign a particular physician, pharmacy, or other provider to a recipient in cases where recipient abuse is evident. The providers must agree to serve as primary providers; physicians are not required to accept this designation. Recipients in this aspect of the WMAP will be issued a special card which contains the name(s) of the primary provider(s). If a physician encounters such a recipient seeking nonemergency service and the physician is not identified by name on the card, delivery of the service will *not* be reimbursed. This program is designed to remove the recipient "shopper" from abusing the program.

8. ***Maintenance of Certification:*** Physicians and other providers are required to advise DHSS of changes in ownership and to maintain records of services provided for a period of five years. The State Medical Society of Wisconsin recommends generally that physicians retain records of operations for a six-year period. Examples of "records" include contracts with other persons or organizations who furnish items or services paid in whole or part by Medicaid funds, Medicaid billings necessary to disclose the nature and extent of services provided to recipients, and all prescriptions which are used to disclose the nature and extent of services provided and billed to the WMAP.

9. ***Changes in Mental Health Services:*** Finally, one of the most controversial portions of the rule deals with services in the mental health program of the WMAP. Psychotherapy in particular has been the subject of significant charges of abuse and misuse. The Department has publicly admitted that these problems lie with providers other than physicians. The costs connected with psychotherapy have been difficult to predict through the life of the program and consistently have involved the expenditure of dollars beyond the anticipated amounts. At the time the Legislature considered the rule in conjunction with the 1979-81 biennial budget, the Department proposed and obtained legislative approval for reductions in the number of persons who would be authorized to provide psychotherapy as independent providers.

   Under the provisions of the final language of the rule, only physicians who have completed a residency in psychiatry and psychologists may deliver psychotherapy as "independent" providers. Other practitioners, such as persons with masters in social work, nurses with training in psychiatric nursing, etc must now deliver such care only via a direct physician prescrip-

tion and within the walls of a mental health facility. Of course, any of these persons may work under the direct supervision of a psychiatrist, but they are not "direct billing" providers.

This portion of the rule poses several interesting and controversial concepts of practice. First, only physicians may prescribe psychotherapy, but only psychiatrists and psychologists may *deliver* psychotherapy. This provision invokes a principle not before seen in the program; *ie,* the "use" of a specialty within medicine by name. Until this time, the state laws and regulations have reflected a general philosophy that "a physician is a physician is a physician." No legislative attempt has been made to "define" medical specialties.

Second, the psychotherapy portion of the rule retains an earlier policy of the Department that any psychotherapy performed beyond 15 hours of care, or $500 of reimbursement, requires prior authorization. Little may be offered in defense of these limits or "thresholds" other than the fact that they are historical, and arbitrary. Fortunately for psychiatry, the rule also requires that these prior authorization requests by psychiatry will be reviewed by physicians and not individuals with lesser training credentials. These limits are not unique to the Medical Assistance program. General insurance policies sold in Wisconsin often contain $500 annual reimbursement limits on psychiatric services, a concept opposed by the State Medical Society.

In spite of these general concerns, the mental health sections have been radically altered since early drafts. While it is unusual in this type of format, I am compelled at this point to indicate my personal appreciation to Dr Charles Landis and the SMS Committee on Mental Health for their willingness to review these issues in depth, spend considerable time discussing alternatives, and for their patience in providing careful advice to both myself and the other members of the Alliance staff involved with the rule.

In November 1979 the Council of the State Medical Society of Wisconsin endorsed a recommendation of the Physicians Alliance Commission that SMS withhold acceptance of the rule/agreement pending resolution of three problems with the psychotherapy section. These sections proposed to prohibit the use of certain types of drugs in inpatient settings, prohibit what was called "self-referral," and prohibit reimbursement for psychiatric consultation.

These three sections will be amended as soon as possible because of the Department agreement with the Alliance that they are poorly drafted, without proper justification, and unworkable.

THE PROVIDER HANDBOOK

In an attempt to provide as much guidance to physicians and others regarding the provisions of the rule, the Department has developed a loose-leaf book called the *Provider Handbook.* These handbooks, which already have been distributed in many areas, "translate" many of the specific provisions of the rule into language that not only reflects the rule but departmental advice on compliance. This handbook should be a valuable resource tool for the physician's office and clinic/business manager in program participation. Periodic updates to the handbook as well as regular provider bulletins are the responsibility of the Provider Relations office within DHSS's Bureau of Health Care Financing.

PHYSICIAN REIMBURSEMENT

As mentioned earlier, the WMAP reimburses physicians according to the dictates of the Title 18 (Medicare) profiles. Following the decision by Dane County Circuit Court that the fee freeze of 1974 by then Governor Patrick Lucey was without legal justification, the Department implemented a reimbursement system which pays physicians the lesser of actual charge, customary-usual-reasonable charge, or the charge indicated by the 75th percentile of all like service charges paid by Medicare for the physician's geographic region. Wisconsin is divided into about a dozen such regions for Medicare.

This system is one which represents the maximum allowable reimbursement according to federal law. As a practical matter, it is the 75th percentile approach which controls physician payments. It is important to note that this is the 75th percentile and *not* 75 *percent* of the composite charges.

The other 48 states with Medicaid programs use a variety of reimbursement mechanisms. Except for the statutory formulas used for hospitals and nursing homes mentioned earlier, virtually all other providers in Wisconsin are paid according to fee schedules. Some other states utilize fee schedules for physician services. Others use profile systems. Some limit reimbursement to a fixed percentage of usual, customary, and reasonable. One state even uses a fee schedule established by the state medical association!

It is clear from recent trends in the Wisconsin program that the state may be forced to consider

other types of reimbursement systems. Some individuals predict that by 1981 the Medicaid budget may approach $1 billion per year of the biennium. Drug payments may soon replace physician reimbursement as the third largest category of claims paid.

The alternatives to physicians seem to be limited. The advantage of the current system is that reimbursement under Medicaid flows from payments and charges to Medicare. In effect, physicians may impact their Title 19 reimbursement by continuing to charge actual charges to Title 18, including any increases. Title 19 payments will ultimately reflect that increase, although anywhere from 12-18 months later.

Fee schedules have the attractive feature of providing a clear indication as to what Medicaid reimbursement will be from the program. Charges for service X at fee Y will be paid at fee Y. The risk in any established fee schedule is the potential for a lack of fee adjustment over time; especially in a time of high inflation and rapidly increasing business costs. What may be an acceptable fee today may fail to meet even a fraction of cost later, and there is always the possibility that authorized Medicaid budgets may prohibit adjustments.

The likelihood is that proposals to change reimbursement for physicians in the next several years will be seriously explored by the Department and the Legislature. What those explorations will discover is literally "anybody's guess."

PHYSICIANS ALLIANCE COMMISSION RECOMMENDATIONS

On December 14, 1979, the Physicians Alliance Commission of the State Medical Society reviewed the Department's proposals for changes in the psychotherapy program and found them to be acceptable and appropriate. Earlier in the year the Commission had endorsed the content and format of the new provider agreement. Later that month all members of the Society were contacted by letter to indicate the support for the rule and agreement and to urge physicians to participate as providers in the program. While reimbursement continues to be a problem in many areas of the state, this rule was not an attempt to change that methodology. That likely will become the next issue for the WMAP. ■

SAMPLE OF PROVIDER AGREEMENT:

STATE OF WISCONSIN

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

* * *

PROVIDER AGREEMENT

The State of Wisconsin, Department of Health and Social Services hereby enters into agreement with

_____

a provider of health care services, to provide services under Wisconsin's Medical Assistance Program subject to the following terms and conditions:

1. The provider shall comply with all federal laws relating to Title XIX of the Social Security Act and State law pertinent to Wisconsin's Medical Assistance Program.

2. The Department shall reimburse the provider for services and items properly provided under the program in accordance with the payment schedule entitled "Terms of Provider Reimbursement" attached hereto and incorporated herein by reference.

_____ Name of Provider	STATE OF WISCONSIN DEPARTMENT OF HEALTH and SOCIAL SERVICES
_____ Address	
BY: _____	
TITLE: _____	BY: _____
DATE: _____	DATE: _____

THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE

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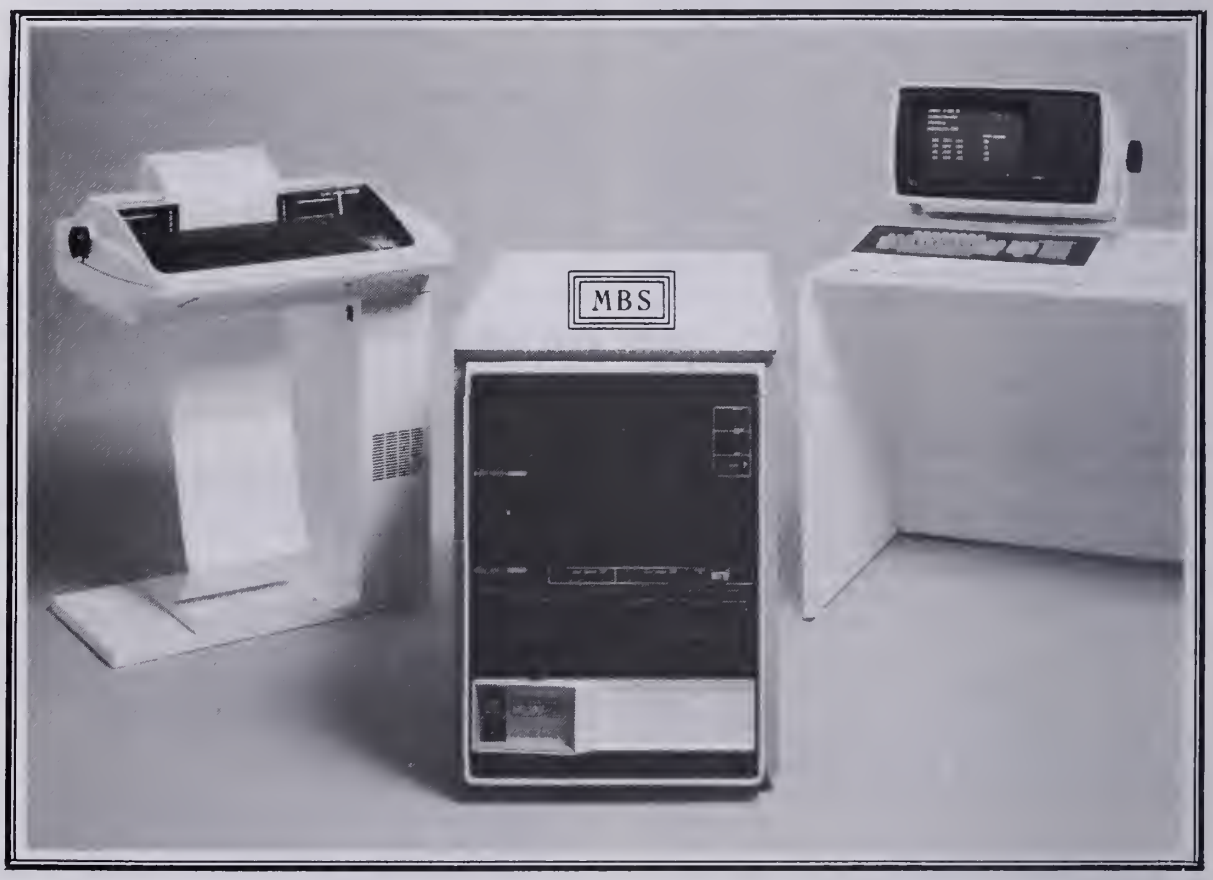

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Scientific Medicine

REFER TO: Caplan RH, Pagliara AS: Treatment of hyperthyroidism during pregnancy. *Wisconsin Med J* 79:33-37 (Jan) 1980

KEY WORDS: Hyperthyroidism, antithyroid drugs: propylthiouracil, methimazole, pregnancy complications, neonatal hyperthyroidism

Treatment of hyperthyroidism during pregnancy

Robert H Caplan, MD and **Anthony S Pagliara, MD**
La Crosse, Wisconsin

•From 1971 to 1977, fifteen hyperthyroid pregnant patients were treated at the Gundersen Clinic. During the last months of gestation, 50 to 150 mg of propylthiouracil (PTU) maintained eight mothers in a euthyroid or slightly hyperthyroid state. One patient developed hypothyroidism after two months of methimazole treatment (30 mg per day). After discontinuation of the drug, she became euthyroid. The infants of these nine mothers were normal.

One patient, allergic to both PTU and methimazole, was treated by thyroidectomy. Subsequently, she delivered a normal baby. One severely hyperthyroid mother, treated with large doses of PTU and iodides, gave birth to an infant who was transiently hypothyroid. Two women with severe hyperthyroidism and serious nonthyroidal diseases suffered spontaneous abortions.

Our experience supports the concept that propylthiouracil prescribed in the lowest possible dose is the best treatment for the majority of hyperthyroid pregnant women.

OPTIMAL TREATMENT of the pregnant hyperthyroid patient accomplishes control of the prospective mother's illness and allows for a healthy infant whose future physical and mental development are normal. Because hyperthyroidism rarely complicates pregnancy,[1-2] investigators have not conducted controlled therapeutic studies and authorities disagree about which therapy is best. Some experts advocate antithyroid drug treatment,[1-6] others combine thyroid hormone with antithyroid agents,[7] while a third group recommends subtotal thyroidectomy.[8] Because of the lack of unanimity, we reviewed the Gundersen Clinic experience and the recent literature regarding the treatment of hyperthyroidism associated with pregnancy.

Materials and Methods. We treated 15 hyperthyroid pregnant women from January 1971 to December 1977. During this period, 5,644 women were delivered. Therefore, the incidence of hyperthyroidism associated with pregnancy at the Gundersen Clinic was 0.27%. The diagnosis of hyperthyroidism was made by clinical criteria, by detecting an elevated free thyroxine index (FTI), and by response to specific therapy.

Prior to pregnancy, three patients had been treated with antithyroid drugs, four with radioactive iodine, and one by a subtotal thyroidectomy; the remaining seven had not been treated. Although retrospective evaluation was difficult, 10 patients were probably hyperthyroid and four were euthyroid at the time of conception.

We prescribed propylthiouracil (PTU) to 15 patients at eight-hour intervals in daily doses initially totaling 150 to 800 mg. One patient ex-

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Table 1 -- Outcome of fifteen hyperthyroid pregnancies

Patient Number	Age (yr)	PTU Initial Dose (mg/day)	PTU Final Dose (mg/day)	Other Medications	Total Weeks of Treatment	Maternal Status	STATUS OF NEWBORN				Comments
							Outcome	Sex, Weight (gms)	Goiter	Thyroxine	
1	23	300	150	l-thyroxine 0.3 mg/day	26	Mildly hyperthyroid	Normal term	Male 3030	0	Normal	Vesicles transiently present on baby's skin
2	18	250	50		12	Euthyroid	Normal term	Female 3050	0	Normal	Vesicles transiently present on baby's skin
3	36	300	50		22	Euthyroid	Normal term	Female 3410	0	---	
4	17	30*	5*		40	Euthyroid	Normal term	Male 2780	0	Normal	
5	23	450	50		28	Euthyroid	Normal term	Female 3230	0	Normal	
6	33	300	150		24	Euthyroid	Normal term	Female 3200	0	---	
7	39	150	50		19	Euthyroid	Normal term	Male 3600	0	Normal	
8	24	150	50		28	Euthyroid	Normal term	Female 3420	0	Normal	
9	24	30*	0		8	Transiently hypothyroid	Normal term	Female 4400	0	Normal	No therapy needed during the last 5 months of pregnancy
10	24	300 30*	--	SSKI Propranolol	6	Transiently hypothyroid postop	Normal term	Male 3860	0	Normal	Subtotal thyroidectomy because of serum sickness from PTU and methimazole
11	29	600	1200	SSKI	5	Moderately hyperthyroid	Transiently hypothyroid/term	Male 3400	0	Low	T_4 normal at 3 days; baby healthy at 6 months
12	23	600	600	SSKI	4	Severely hyperthyroid	Spontaneous abortion	---	---	---	Severe uterine bleeding, anemia and congestive heart failure
13	32	800	800	SSKI	2	Severely hyperthyroid	Spontaneous abortion	---	---	---	Exploratory laparotomy 10 days before abortion
14	24	600	600		6	Moderately hyperthyroid	Therapeutic abortion	---	---	---	Unmarried, therapeutic abortion
15	21	300	--				---	---	---	---	Lost to followup

* Methimazole. PTU=propylthiouracil. SSKI=saturated solution of potassium iodide.

perienced a metallic taste and another developed a skin eruption. Both were successfully treated with methimazole (Tapazole®). The patients were examined and an FTI obtained at no less than monthly intervals. The amount of antithyroid drugs was reduced when the FTI fell into the normal range in an attempt to use the lowest possible dose. Early in the series, thyroid hormone supplementation was prescribed for one patient.

Three severely hyperthyroid patients were treated with a saturated solution of potassium iodide (SSKI) in addition to large doses (600 mg or more daily) of PTU. One patient developed serum sickness with both PTU and methimazole treatment; she received a subtotal thyroidectomy after therapy with SSKI and propranolol (Inderal®).

A pediatrician examined all infants delivered at the La Crosse Lutheran Hospital. A thyroxine concentration was measured on umbilical cord or peripheral venous blood obtained from these infants. The results of the thyroxine determinations (Table 1) were designated normal or low because several methods and normal ranges were used during the period of the study. Information regarding the status of two infants delivered at other hospitals was obtained from the attending physicians. One patient was lost to followup.

Results and Discussion. Hyperthyroidism complicated 0.27% of pregnancies cared for at the Gundersen Clinic. Because this illness rarely occurs during gestation,[1,2] investigators have not conducted controlled or prospective therapeutic studies. Although all authorities agree that radioactive iodine treatment is contraindicated during pregnancy, controversy continues whether antithyroid drug therapy,[1-6] combined treatment with antithyroid drugs and thyroid hormone,[7] or subtotal thyroidectomy[8] provide optimal management.

We prescribed the lowest dose of antithyroid drugs that maintained the mother in a euthyroid or slightly hyperthyroid state. Because PTU blocks the peripheral conversion of thyroxine (T_4) to triiodothyronine (T_3), the concentration of the

metabolically more active T_3 falls faster than with methimazole treatment. Furthermore, methimazole has been associated with scalp defects or aplasia cutis in the offspring of mothers treated with this agent.[9] Finally PTU crosses the placenta less readily than methimazole.[10] Thus, Burrow advocates the administration of PTU rather than methimazole during pregnancy.[2] Although some hyperthyroid patients are successfully treated by a single daily dose of PTU, this agent has a short half-life and was given in divided doses. For patients with mild to moderate symptoms, initial doses of 100 mg of PTU every eight hours sufficed. The patients were examined and an FTI measured at no less than monthly intervals. Pregnancy ameliorates the symptoms of hyperthyroidism.[11] We anticipated this effect, reduced the dose of antithyroid drug when the FTI fell into the normal range, and did not wait for the FTI to fall into the hypothyroid range. A further decrease in the FTI or failure of the FTI to rise after a reduction in the PTU dose, suggested that a further dosage reduction was possible.[3] By the end of gestation, patients one through eight (Table 1) were maintained in a euthyroid or slightly hyperthyroid state on 50 to 150 mg PTU per day. Goiter, clinical findings of hypothyroidism, or depression of the T_4 were not found in the infants of these women.

Critics of antithyroid drug treatment emphasize that these agents cross the placenta, block fetal thyroid hormone synthesis, stimulate fetal thyrotropin (TSH) production, and can produce goiter, hypothyroidism, or mental deficiency in the infant. In previous studies, however, mothers delivering goiterous infants were frequently treated with large doses of antithyroid drugs, iodides, or both.[12] In other cases neonatal hyperthyroidism (see below) caused the goiter.[9] Because many women receiving large doses of antithyroid drugs have given birth to normal infants, factors other than the dose of antithyroid drugs contribute to the development of fetal goiter.[2] When goiter does occur, it is not large and the majority of goiterous infants suffer no subsequent ill effects from the drug.[9] Burrow and coworkers[13] studied the intellectual and physical development of 15 children who had been exposed to PTU in utero and compared the findings with those obtained from 18 unexposed siblings. Although the study group was small, the authors concluded that PTU therapy had no apparent adverse effect on growth and development.

The results of this study (Table 1) agree with other reports.[1-6] They suggest that fetal goiter does not occur when the mother receives less than 100 mg PTU per day[14] and that low-dose antithyroid drug therapy satisfactorily manages most pregnant hyperthyroid women.[1-6]

Patient nine developed a low FTI after eight weeks of treatment with methimazole (Table 1). This woman received a therapeutic dose of radioactive iodine 18 months prior to gestation. After the patient discontinued the antithyroid drug, the FTI returned to normal and she remained euthyroid without treatment for the remaining 5 months of pregnancy. She gave birth to a normal euthyroid infant. The fetal thyroid begins to function at approximately 12 weeks gestation.[1] Researchers have not clarified whether *maternal* thyroid hormones are necessary prior or subsequent to this period for normal fetal growth and development.[1] Although this issue is unresolved, physicians should avoid the production of maternal hypothyroidism by evaluating patients at frequent intervals and by prescribing the lowest dose of antithyroid drug that will maintain the prospective mother in a euthyroid or slightly hyperthyroid state. Pregnant women tolerate mild degrees of hyperthyroidism without difficulty and a physician should error on the side of undertreatment rather than overtreatment.

Some investigators add replacement doses of thyroid hormone to antithyroid drugs[7] because they believe that thyroid hormones cross the placenta and prevent fetal goiter and hypothyroidism. Although the first patient in this series was treated with combined therapy, we currently agree with others [1-6] that this approach is unnecessary. Review of the combined treatment protocol reveals that the daily dose of antithyroid drug was in reality low. Mestman and coworkers[4] suggested that prematurity and associated problems were lower in infants of women treated only with antithyroid drugs. Patients treated with antithyroid drugs plus thyroid hormone required higher doses of antithyroid drugs to reach a comparable metabolic status. Since thyroid hormones cross the placenta poorly while antithyroid drugs cross easily,[1] combined therapy presumably increased the exposure of the fetus to antithyroid drugs. Furthermore, in another study, the administration of large amounts of T_3 to two hyperthyroid mothers did not prevent fetal hypothyroidism.[15]

Three severely hyperthyroid patients (Table 1) were treated with large doses of PTU. Antithyroid drugs inhibit the synthesis of thyroid hormones; the time required to control hyperthyroidism depends upon the amount of hormones stored in the thyroid gland and on the rate of metabolism of serum thyroid hormones and may be several weeks. Therefore, 5 drops (180 mg) of SSKI were administered to the severely hyperthyroid patients. This agent blocks secretion as well as synthesis of thyroid hormones and exerts a beneficial effect within 24 hours. Iodides, however, chronically administered in doses as low as 12 mg daily, have produced huge fetal goiters and asphyxiation

of infants during delivery.[16] Thus, physicians should prescribe iodides only to severely hyperthyroid patients or for preparation for thyroidectomy in patients allergic to antithyroid drugs; the drug should be administered for as short a duration as possible.

Patient 11 suffered from hyperthyroidism for two years. She did not seek treatment until the 35th week of gestation at which time she was severely thyrotoxic. Because delivery can precipitate a thyroid crisis in the mother, a large dose of PTU (600 mg per day) was prescribed. After one week of treatment, she remained severely hyperthyroid. The dose of PTU was increased to 1200 mg daily and SSKI was added. Although her hyperthyroidism was not completely controlled after five weeks of treatment, she delivered a healthy infant without difficulty. The infant did not have a goiter, but the level of T_4 in cord blood was low. By the third postpartum day, though, the serum T_4 had risen to a normal value and the infant did not require thyroxine therapy. At six months of age, the baby remained euthyroid and developed normally.

Two patients had serious nonthyroidal illnesses as well as severe hyperthyroidism. Patient 12 had persistent vaginal bleeding, severe anemia, and congestive heart failure. Abdominal pain and a pelvic mass required exploratory laparotomy in patient 13. These patients suffered spontaneous abortions before the hyperthyroidism was completely controlled. However, the serious nature of the nonthyroidal diseases probably precipitated premature delivery.

Patient 10 developed serum sickness with both PTU and methimazole treatment. Therefore, she was treated with propranolol. This beta adrenergic blocking agent decreases tachycardia and other signs and symptoms of beta adrenergic stimulation. Some investigators prescribe propranolol as sole therapy for hyperthyroidism during pregnancy because fetal goiter should not occur.[17] Although propranolol provides symptomatic improvement, it does not decrease the abnormal metabolism; the hyperthyroidism is not truly controlled but "masked." In addition, beta adrenergic blocking agents increase uterine irritability and may precipitate premature labor.[18] Furthermore, infants whose mothers receive this drug may experience intrauterine growth retardation, respiratory depression, bradycardia, or hypoglycemia.[18] For these reasons, Burrow does not recommend propranolol for long-term therapy of hyperthyroid pregnant patients.[2] However, the drug, is a useful agent, particularly when combined with iodides, for rapid control of hyperthyroidism or treatment of severe thyrotoxicosis. Some physicians prepare patients for thyroidectomy solely with propranolol.[19] Because thyroid storm can rarely occur in patients treated only with propranolol, other investigators believe this treatment is potentially dangerous.[20] Therefore, patient 10 was prepared for surgery with SSKI as well as propranolol. An extensive subtotal thyroidectomy was performed. Postoperatively, the FTI fell to low levels and the patient was treated with l-thyroxine. She subsequently delivered a euthyroid baby.

Talbert and coworkers,[8] on the basis of their own data and a review of the literature, advocate subtotal thyroidectomy for the management of pregnant hyperthyroid women. Of 223 surgically treated patients, these authors reported that 207 (93%) had a favorable outcome when compared to 147 of 173 (85%) healthy infants from drug-treated mothers. Surgical studies, however, have a built-in bias.[5,20] Surgeons prepare all patients for surgery with drugs and usually delay subtotal thyroidectomy until the second trimester. Because abortions occur more commonly in the first trimester, a patient aborting at this time is considered a medical failure. In addition, severely hyperthyroid patients are not candidates for surgery; and if they abort, such patients are also defined as medical failures. The frequency of abortions is the major difference between surgically and medically managed series. If one excludes abortions, the success rate for both therapies is nearly identical.[5] Although operative mortality is rare in thyroidectomy, death can result from any surgical procedure. Furthermore, hyperthyroidism can persist or hypothyroidism develop after subtotal thyroidectomy.[22] In addition to recurrent laryngeal nerve injury, thyroidectomy produces hypoparathyroidism in up to 3% of patients and partial hypoparathyroidism in 28% of patients. Because of the complications of subtotal thyroidectomy,[22] and because studies have failed to provide convincing evidence that surgical treatment is superior to medical treatment,[5] we recommend subtotal thyroidectomy only for patients who are intolerant of antithyroid drugs, refuse to cooperate with a medical regimen, or cannot be controlled with low doses of antithyroid drugs.

Three women developed adverse effects from PTU. One patient with a metallic taste and another with a skin eruption were successfully treated by substituting methimazole as the antithyroid drug. Another patient developed serum sickness with both drugs. The most common complications of PTU therapy — skin rash, pruritus, nausea, and a metallic taste — occur in approximately 4% of patients.[21] Because a high degree of cross reactivity does not occur, one frequently can continue drug therapy with methimazole. However, the rare development of agranulocytosis or hepatitis requires immediate discontinuance of all antithyroid drugs. Two infants, described in detail previously,[23] were born

with vesicular skin lesions. Bacterial, viral, or toxic etiologies could not be proved, and we postulated that transplacental transfer of PTU produced the allergic skin eruptions in the neonates. The lesions quickly subsided.

The severity of hyperthyroid symptoms commonly increase postpartum.[10] Therefore, the dose of PTU was increased to 100 mg every eight hours after delivery. Because antithyroid drugs are secreted in milk, the mothers were advised not to breast feed.

After delivery, physicians must carefully evaluate the newborn infants for the presence of neonatal hyperthyroidism,[1,21] as well as drug-induced goiter and hypothyroidism. Although the syndrome is rare, unrecognized neonatal hyperthyroidism is a serious if not fatal illness. Because PTU administered to the mother may inhibit the clinical expression of hyperthyroidism in the newborn, the disease may not be clinically apparent for 5 to 10 days after delivery.

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Abstracts

Ultrasonic distinction of abscesses from other intra-abdominal fluid collections

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The ultrasonic examination of 103 intra-abdominal fluid collections, the nature of which was known from needle aspiration, spontaneous rupture, surgical exploration or autopsy were reviewed and their ultrasonic properties were determined. Abscesses were generally elliptical or spherical in cross-section without re-entrant angles and contains either dependent or diffusely distributed weakly echoing material. Hematomas over 24 hours old contained coarse clumps of strongly echoing material, were elliptical or spherical and had a finely irregular wall. Lymphoceles had a sharply defined wall and were usually echo free although sometimes they were loculated. Lymphoceles may have the appearance of internal echoing due to numerous internal septa. Urinomas were similar to lymphoceles except that they were unilocular and were somewhat more irregular in outline. Collections of ascites were totally echo free except for loops of bowel floating within them and had a highly irregular outline. The walls were sharply defined. Fluid filled loops of bowel were almost invariably multiple, all of much the same size and contained weakly echoing material.

There was some overlap of properties particularly between abscesses and hematomas so that it was not possible to determine the nature of the fluid within a collection with certainty. On the basis of the ultrasonic examination alone, however, the range of diagnostic possibilities could often be narrowed. ■

REFER TO: Sty JR, Babbitt DP, Boedecker RA, and Olson D: "Tropical Pyomyositis." *Wisconsin Med J* 79:38-39 (Jan) 1980

KEY WORDS: Pyomyositis, musculoskeletal pain, parasitic infection, *Staphylococcus aureus*, tropical disease

"Tropical Pyomyositis"

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•The authors describe an unusual case of "tropical pyomyositis" in a youth residing in Wisconsin. The radiographic and scintigraphic observations are illustrated.

"TROPICAL PYOMYOSITIS" as a disease entity was described more than 90 years ago.[1] In tropical countries acute bacterial pyomyositis is not rare and, therefore, is included in the differential diagnoses of patients who have musculoskeletal pain, tenderness and swelling, with or without fever.[2,3] In fact 5% of surgical hospital admissions in tropical areas is for pyomyositis.[4,5]

However, in the Midwest the problem is unusual, and it is the lack of familiarity with the entity that represents the chief obstacle to correct diagnosis.[6,7]

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Case Report. The patient was a healthy 15-year-old male who developed pain over the lateral aspect of his left leg while running. These symp-

FIGURE 1—Blood pool image (99mTc methylene diphosphonate). Minimal increased activity in the region of the periosteum of the proximal fibula.

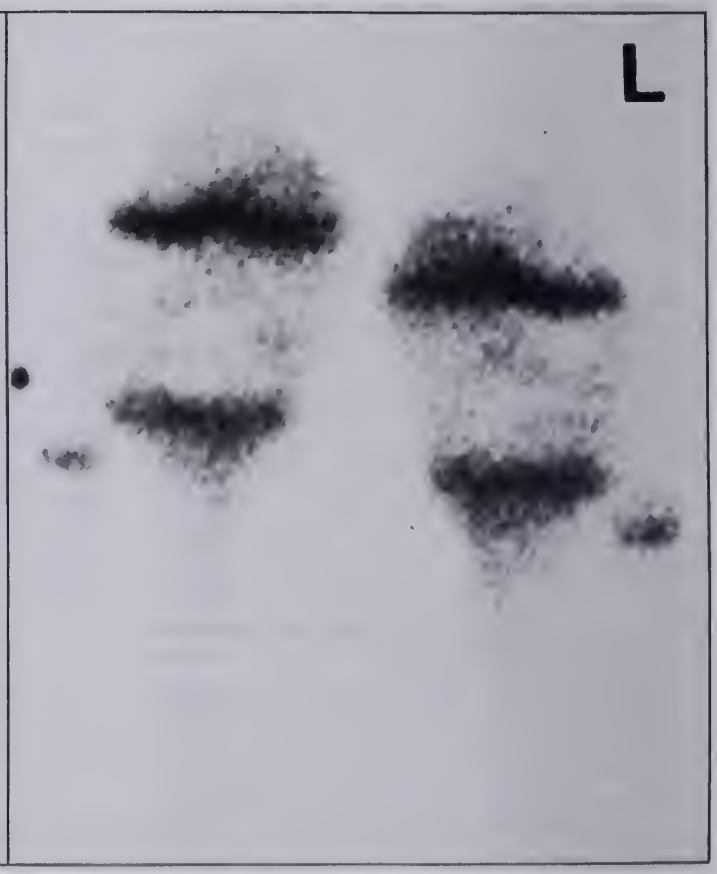

FIGURE 2—Delayed bone image. Normal. No evidence of osteomyelitis.

FIGURE 3—Lower leg venogram. Patent venous system with a large mass in the lateral head of the gastrocnemius displacing veins. No evidence of thrombophlebitis.

toms persisted for two days before being evaluated.

His admission evaluation documented an elevated temperature of 40 C and localized tenderness in a region posterior and inferior to the head of the fibula. Laboratory data consisted of an abnormal white blood cell count with a left shift and an elevated erythrocyte sedimentation rate. Blood cultures were negative. Aspiration of the painful region and fibula was unproductive. X-ray studies of the region were reported as normal.

On the second hospital day a radionuclide bone scan and venographic studies were performed. The observations are illustrated in Figures 1, 2, and 3.

The leg was surgically explored and 40 ml of purulent material was evacuated from the lateral head of the gastrocnemius. The material was cultured and grew coagulase-positive *Staphylococcus aureus*. Bone aspirate was negative.

Discussion. The onset of acute or subacute moderate localized pain, with minimal erythema, presents a diagnostic dilemma for the clinician and radiologist. The differential diagnoses include osteoymelitis, ruptured tendon with hematoma, thrombophlebitis, and pyomyositis.

The pathogenesis of "tropical pyomyositis" has not been completely explained. Predisposing factors that have been incriminated include trauma,[8] Vibrio infection,[9] parasitic infection, and hemoglobinopathies.[10] Coagulase-positive *Staphylococcus aureus* is the causative organism in greater than 95% of the reported cases.[3,4,10] The route of entry is usually unknown, and generally the blood cultures are negative.

Bone imaging and the leg venographic studies aided in excluding thrombophlebitis and osteomyelitis as a cause of the pain and fever. Localization of the problem was useful in tailoring a surgical approach to the lesion. A computed tomographic (CT) study or a radionuclide Ga-67 scan would have been a more direct method to document pyomyositis. However, "tropical pyomyositis" was not our initial clinical impression because of its rarity in Wisconsin.

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REFER TO — Forster FM: Brain tumors in chronic epilepsy. *Wisconsin Med J* 79:40-43 (Jan) 1980
KEY WORDS — Epilepsy, brain tumor, computer tomography scan

Brain tumors in chronic epilepsy

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When epileptic seizures begin after the age of 20 or particularly after the age of 30, there is special concern regarding their etiology. Brain tumors are not the most common cause of seizures in this age group, but their occurrence is of special concern. The literature dealing with epilepsy in patients with brain tumors is voluminous. Tissot[1] noted that, in 1680, Plater first reported the occurrence of seizures in a patient with a tumor of the forebrain. Twenty-two years ago, Tonnis[2] carefully reviewed the literature relating to brain tumors and epilepsy. Penfield and Erickson[3] surveyed their own work and other literature regarding the occurrence of seizures in patients with brain tumors.

Of particular interest is the occurrence of seizures as the initial symptom of intracranial tumor. Both Penfield and Erickson[3] and Sargeant[4] found that approximately 40% of the patients experiencing seizures secondary to intracranial tumors had seizures as the initial symptom. Therefore, the onset later in life of seizures which are uncomplicated by other symptomatology suggests the possibility that the patient may have a brain tumor.

In general, the occurrence of seizures over a period of years tends to reassure the physician that the patient does not have a neoplasm. However, Douglas,[5] on the basis of questionnaires submitted to appropriate specialists, found evidence contrary to this. He studied the interval between the onset of seizures and the development of the other symptoms leading to the diagnosis of brain tumor. Seventy percent of the patients studied had tumors which became evident within five years of the onset of the seizure. An additional 15% of the patients had evident tumors within 5 to 10 years after the onset of the seizures. However, approximately 3% had a time interval of over 20 years. Therefore, the duration of the epilepsy, even in the absence of other symptoms, is not sufficient to completely rule out the presence of a brain tumor in patients who begin having seizures later in life.

This study supported in part by the Medical Research Service of the Veterans Administration. Presented before the Wisconsin Neurological Society, Oct 14, 1978, at Brookfield, Wisconsin. Publication support provided. Reprint requests to: Francis M Forster, MD, William S Middleton Memorial Veterans Medical Center, 2500 Overlook Terrace, Madison, Wis 53705. Telephone: 608/256-1901. Copyright 1980 by the State Medical Society of Wisconsin.

Other factors in the patient's clinical history other than a brain tumor may be considered as the possible cause of the seizures and obscure the diagnosis. For example, a past significant head injury or the chronic injudicious use of alcohol may lead to the seizures being attributed to these factors.

This paper presents case reports on three patients who had late onset of seizures with a long duration of epilepsy. Each patient had an apparent cause of seizures other than tumor and yet all three patients were found to have brain tumors.

CASE REPORTS

Case 1. In February 1971, a 52-year-old male veteran and ex-truck driver was struck with a steel bar in the left parietal area of the head, but the injury was not considered severe. Three days later, he became febrile (106 F), delirious and had partial continuous epilepsy. He was carefully studied in a Wisconsin clinic and noted to have right hemiplegia with more leg than arm involvement and a Babinski sign. The febrile course and angiography suggested the possibility of a vasculitis. However, biopsy of the temporal artery and testis were normal.

As the fever subsided, the patient's seizures, which lasted one to two minutes, continued intermittently with clonic movements of the right shoulder and paresthesias proceeding down the trunk to the right leg. On occasion the seizures began in the right foot and progressed upward. The frequency of the attacks varied from twice a day to once every several weeks. When the patient was first studied at the Madison VA Medical Center in 1973, he had a spastic gait on the right side, mild weakness of the right arm, and required a cane and foot brace.

The patient was admitted to the VA Medical Center five times within four years and treated with varying doses of phenytoin, primidone, and phenobarbital with temporary success. Because of repeated seizure breakthrough, headaches, and a definite increase in weakness of the right extremities (especially the upper extremity), the patient underwent an extensive computerized tomographic (CT) scan. It was not clear whether the increase in weakness was real or a manifestation of Todd's paralysis. The results of various laboratory studies on this patient are shown in Table 1.

Because the CT scan was abnormal, the patient underwent left parietal craniotomy in September 1977. This procedure revealed a malignant neoplasm presenting on the surface parasaggitally, extending into the frontal and parietal lobes. The nature of the tumor was difficult to determine; however, it was thought to be a glioblastoma multiforme with sarcomatous changes.

The patient was treated with radiotherapy and chemotherapy. Eighteen months later he is ambulatory with assistance, his hemiplegia is at the preoperative level, and he only has occasional minor seizures.

Case 2. A 60-year-old World War II male veteran and ex-bartender began having seizures in 1963. The seizures appeared generalized without focal components. The patient had a history of chronic alcoholism with two extended hospitalizations in 1957 and 1960. He had suffered numerous injuries while intoxicated.

When the patient was hospitalized in 1963, examination revealed hepatomegaly, an impairment of memory, and arthropathies as the result of the various traumas. X-ray films of the skull were normal. The electroencephalogram (EEG) was mildly abnormal, showing an excessive range of 15 to 20 per second low voltage fast activity in all leads with questionable diffuse slow waves in the frontal parietal areas. Pneumoencephalogram was within normal limits. The patient was placed on phenytoin and phenobarbital therapy.

When next admitted in October 1968, the patient stated that he had been seizure-free for five years, but that the seizures had now begun to recur. Neurologic examination was negative and x-ray films of the skull were normal. Brain scan was unremarkable. The EEG repeatedly showed a grade III dysrhythmia, focal left sylvian. An angiogram showed a mild concave bowing away of the anterior cerebrals from the left side and widening of the anterior cerebral-left middle cerebral distance by about 1 cm. The lesion was considered atrophic, but verification was made by a pneumoencephalogram. This showed some widening of sulci and indicated cortical atrophy. Spinal fluid contained six white blood cells with a total protein of 72. The patient was again placed on phenytoin and phenobarbital therapy.

The patient was next seen in the Neurology Clinic in April 1977. He had had some difficulty from time to time with seizures which were apparently related to excessive drinking. It was noted then that the patient had some occasional stuttering dysphasia.

When seen in the Epilepsy Center Clinic in June 1978, the patient complained of difficulty in talking. He could not find names of objects, perceive his errors and, occasionally, comprehend commands. He also had marked mathematical impairment as evidenced by his inability to make change. He also made occasional errors in laterality and in recognizing fingers.

An audiovisual split-screen study of the patient and his EEGs revealed no changes in his EEG during the episodes of mathematical impairment. Therefore, the computational problem was not considered to be the basis of seizure disturbance. A CT scan (Fig 1) showed a large mass in the left frontal

Table 1 — Laboratory test results in Case 1

Laboratory test	*Private clinic*		*Madison VA Medical Center*				
	March 1971	November 1971	May 1973	October 1973	October 1975	October 1976	October 1977
Skull x-ray films	Normal		Normal	Normal	Normal		Normal
Angiogram	Abnormal	Normal	Normal				Abnormal
Brain scan	Two abnormal scans, third scan normal		Normal	Normal			Normal
CT scan				Calcification of the left temporoparietal region after traumatic or vascular accident			Abnormal
Electroencephalogram	With spikes left parietal	Improved	Left temporal occipital abnormality	Left temporal abnormality	Normal	Mildly abnormal	Normal
Cerebrospinal fluid	Normal						

FIGURE 1 — CT scan of Case 2. Large mass in left frontoparietal area with compression of left lateral ventricle and displacement of ventricular system to the right.

FIGURE 2 — CT scan of Case 3. Large mass in right thalamic area projecting into right lateral ventricle and extending toward cortical surface.

parietal region with displacement of the ventricular system to the right. Angiography confirmed the mass as a neoplasm. A left frontal parietal craniotomy was performed and revealed a large tumor which was a grade II astrocytoma.

Case 3. In 1966, a 51-year-old male veteran and construction worker fell through a manhole and plummeted some 12 feet. He became unconscious and suffered fractures to the extremities. Two years later, he began to have partial complex and major motor seizures, the latter being nocturnal. He was first admitted to the Madison VA Medical Center in December 1973, with seven more admissions during the next four and one-half years. Reasons for his admissions virtually alternated between drug toxicity and an increase in seizures.

It was difficult to bring this patient's seizures under control. He had been treated since their onset with phenytoin, primidone, phenobarbital, carbamazepine, and clorazepate dipotassium (Tranxene®). It was generally felt that he had a very narrow range between toxicity and seizure breakthrough.

During these repeated admissions, the patient had normal skull x-ray films and five normal nuclear brain scans. His EEGs on the first admission showed right and left mesial temporal spiking discharges. However, there was no x-ray confirmation of the nasopharyngeal electrode placement. Subsequent recordings showed focal theta in the right anterior temporal region interspersed with normal EEGs on different samplings. During the last admission, some delta activity occurred in the right temporal region.

The patient was seen in the Ear, Nose and Throat Clinic because he demonstrated some hearing loss. The possibility of an acoustic neuroma was investigated. CT scan showed no posterior fossal lesion, but did indicate a large right parietal lesion with displacement of the ventricle (Fig 2).

Neurologic examinations have continued to be normal, including detailed cortical sensory evaluations. Because of his excellent overall condition and certain social problems, the patient has not yet undergone surgery. His CT scans and EEGs are repeated monthly, and he is being followed closely for changes in his clinical condition.

Discussion. Three patients had the onset of their seizures late in life. In each patient the epilepsy had lasted between 8 and 13 years. There was a reasonable apparent cause for the seizures in each of the patients, either head injuries or injudicious use of alcohol. However, all three patients had brain tumors as the etiologic factor in their seizures.

Despite a long duration of seizures and an apparent etiology, the clinician should be alerted to the possibility of a brain tumor by certain factors. In patients whose only symptomatology is seizures, two of these factors are the development of new symptoms or a significant change in seizure incidence or characteristics. In our first patient the repeated seizure breakthrough and the development of additional symptoms led to the determination of the presence of the tumor. In the second patient seizures were controlled, but the insidious onset of new symptomatology, namely, higher cognitive function impairments, led to the tumor diagnosis. However, the diagnosis in the third patient was serendipitous for there were no changes in seizure incidence or any new symptoms.

Changes in seizure density or characteristics may be obscured by changes in medication dosages, absorption, or metabolism. The monitoring of blood levels, however, can be of value in detecting these changes.

When the presence of a tumor is suspected, confirmation usually depends upon laboratory tests. All three of our patients had repeated skull films, one of them three times and the other two patients five times. All 13 examinations were normal. Nuclear scans, likewise, were of no help in these patients. The first patient had a positive scan during the acute febrile episode at the onset of his illness, but had four negative scans afterwards. The other patients had two and five normal scans each. Angiography was positive in all three patients after their diagnoses had been made by CT scan, but prior to that this procedure was not particularly helpful. In the first patient the first angiogram showed a blush at the time of the acute illness, but this subsequently remitted and repeated angiograms were normal prior to the last admission. The questionable changes in the angiogram and pneumoencephalogram on the second patient were noted five years prior to the tumor diagnosis.

Serial electroencephalography in the first two patients did not indicate the presence of a tumor. Both of the patients had mild abnormalities in earlier tracings and subsequent recordings were normal. However, in the third patient focal abnormalities over the right hemisphere appeared which gradually assumed a delta rhythm. These results might well have been helpful, but the report of bilateral mesial temporal spiking in the first nasopharyngeal sleep recording obscured the significance of these changes. It should be noted that the placement of the electrodes was not confirmed by radiography. Grabow[6] showed that it is possible for electrodes to cross or be misplaced. It is possible that only the right mesial temporal cortex was studied in our patient.

Summary. Patients who begin having epileptic seizures late in life are brain tumor suspects. The presence of other etiologic factors and the duration of the epilepsy do not rule out this possibility. Changes in seizure frequency or patterns or the development of other neurologic signs or symptoms are further alerting factors. The most important laboratory test in these situations is the CT scan. The second most important laboratory test is serial electroencephalography. Routine skull films and nuclear brain scans are of little help in diagnosing brain tumors.

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Abstracts

Septic endarteritis due to intra-arterial catheters for cancer chemotherapy

I. Evaluation of an outbreak. II. Risk factors, clinical features and management. III. Guidelines for prevention.

DENNIS G MAKI, MD; RITA D McCORMICK, RN; STEPHEN J UMAN, MD; and GEORGE W WIRTANEN, MD, Univ of Wisconsin Center for Health Sciences, Madison, Wis: *Cancer* 44:1228-1240, 1979

A cluster of three cases of staphylococcal septic endarteritis originating from percutaneously inserted brachial artery catheters for regional cancer chemotherapy prompted an epidemiologic and clinical study of bacteremic infections associated with this therapeutic modality. Nine cases were identified over a 3½-year period (1.6% of all catheterizations), all caused by *Staphylococcus aureus.* The cluster followed discontinuation of hexachlorophene for scrub of the extremity prior to cannulation; phagetyping suggested the three cases were caused by the patients' own strains of *Staphylococcus.* These infections produced a distinctive clinical syndrome which facilitates implicating the catheter in the genesis of fever occurring in a patient receiving intra-arterial chemotherapy: early localized pain (89%) and hemorrhage (78%), and Osler's nodes distally (44%), later followed by local inflammation (78%), purulence (56%) and signs of systemic sepsis (100%) (each factor, $p \leq .005$). Duration of cannulation did not influence susceptibility to infection. However, difficult cannulations or need for repositioning the catheter ($p = .0096$), prior radiation therapy ($p = .033$), leukopenia ($p < .05$) and hypoalbuminemia ($p < .05$) were all associated with septicemia. In the 25 months since implementation of specific control measures, there have been no further catheter-related septicemias in 310 catheterizations ($p < .001$). Guidelines for prevention and management of these infections are provided. ■

REFER TO—Sty JR, Babbitt DP, Boedecker RA: Unilateral nephromegaly with a pancreatic pseudocyst. *Wisconsin Med J* 79;00-00 (Jan) 1980

KEY WORDS—Pancreatic pseudocyst, nephromegaly

Unilateral nephromegaly with a pancreatic pseudocyst

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Unilateral smooth renal enlargement without focal defects includes renal vein thrombosis, acute arterial infarction, acute pyelonephritis, and obstructive uropathy. Renal vein occlusion in children is usually secondary to infection or dehydration. A case of partial renal vein occlusion secondary to compression from a traumatic pancreatic pseudocyst is presented.

From Milwaukee Children's Hospital, Milwaukee, Wisconsin. Reprint requests to: John R Sty, MD, Department of Radiology, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, PO Box 1997, Milwaukee, Wis 53201. Telephone. 414/931-1010. Copyright 1980 by the State Medical Society of Wisconsin.

CASE REPORT. A 6-year-old boy was being evaluated for a painless abdominal mass. The parents were aware of the mass for about two weeks. His general health was good, and physical examination was normal except for the large epigastric mass. Two months prior to his evaluation he sustained blunt trauma to the abdomen from a bike accident. He was evaluated clinically for nausea and abdominal tenderness, but these symptoms subsided within two days.

His admission laboratory stud-

Abstracts

Interrelationship between coronary artery occlusion, high-density lipoprotein cholesterol, and alcohol intake

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Findings from this study indicate that there is an inverse relationship between coronary occlusion and alcohol intake as well as between coronary occlusion and plasma HDL cholesterol levels.

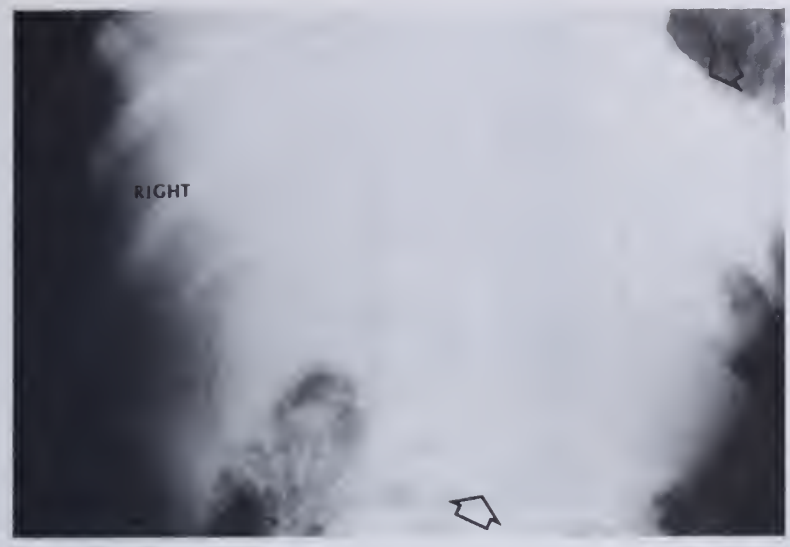
The authors found a positive association between the amount of alcohol consumed and plasma HDL cholesterol levels. They believe that the effect of alcohol on coronary artery disease may be partially explained by the alcohol-induced rise in plasma HDL cholesterol.

Seven hundred and eighteen male patients undergoing diagnostic coronary arteriography participated in this study. The patients were being evaluated because of unstable angina pectoris, moderate to severe stable angina, previous myocardial infarction, or recurrent chest pain of unknown origin.

The average HDL cholesterol level of 79 patients having no or minimal coronary artery occlusion was 47 mg per deciliter, and their average alcohol intake was 7 oz per week. The average HDL cholesterol level of patients with extensive coronary artery occlusion was 43 mg per deciliter, and their average weekly alcohol intake was 4.9 oz.

After adjusting for age, the total cholesterol/HDL cholesterol ratio was the best correlate of the extent of coronary artery occlusion. According to the risk-factor correlation matrix, these figures indicated a statistically significant positive correlation between alcohol intake and HDL cholesterol levels, and inverse correlations between the extent of coronary artery occlusion and HDL cholesterol levels and between coronary artery occlusion and alcohol intake.

The authors conclude that even though less extensive coronary heart disease and alcohol consumption may be associated with higher HDL cholesterol levels, alcohol also may exert an additional effect that is not mediated by the HDL cholesterol changes. ■



ies included a normal blood cell count, urinalysis, and electrolytes. Both urine and serum amylase levels were markedly elevated. A urogram demonstrated a large, smooth left kidney with decreased function (Fig 1A and 1B). An ultrasound examination demonstrated a large pancreatic pseudocyst (Fig 2).

At surgery a pancreatic pseudocyst was found. The pseudocyst was compressing the left renal vein. A cystogastrostomy was successfully performed.

FIGURE 1A—Excretory urogram. Open arrows mark a large extrarenal mass.

FIGURE 1B—Note left renal enlargement (solid arrows) and delayed function.

DISCUSSION. There is a difference in the etiology of pseudocysts in children compared to adults. In adults pancreatic pseudocysts are usually due to complications of alcoholic pancreatitis but may be due to trauma. In contrast most children have a history of accidental blunt trauma to the abdomen.[1] Pseudocysts will vary in location and will correspondingly displace adjacent structures. In the case presented, enlargement of the pseudocyst compressed the left renal vein which resulted in nephromegaly.

FIGURE 2—Posterior transverse scan. Open arrow marks the pseudocyst. Note left renal enlargement.

The rapidity with which the renal vein is occluded determines the response by the kidney.[2] In this case ultrasound was useful in establishing the diagnosis of pancreatic pseudocyst and was indirectly responsible for suggesting compression of the renal vein as the etiology of nephromegaly.

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KEY WORDS — Meconium aspiration syndrome, neonatal respiratory distress, extrauterine pulmonary adaptation

Perinatology

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Prevention of neonatal meconium aspiration syndrome

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EDITORIAL NOTE: The significance of meconium stained amniotic fluid in terms of possible serious sequelae on the neonate has been the subject of several papers in recent pediatric and obstetrical literature. The accompanying article deals with the problem of meconium aspiration syndrome and an approach to its prevention.

Approximately 10% of all deliveries (5000-6000 in Wisconsin each year) are accompanied by meconium staining of the amniotic fluid. About one-third (1/3) of the neonates of these deliveries will have symptomatic respiratory problems because of aspiration of the meconium-stained fluid. Many of these neonates will have complications such as hypoxemia, hypercarbia, pneumothorax, and death. It is all the more tragic when one realizes that 98.4% of meconium-stained amniotic fluids occur in pregnancies $\geq$ 37 weeks gestation.[1] These are babies that otherwise should not have problems of extrauterine pulmonary adaptation.

Many people feel that meconium-stained amniotic fluid is an indicator of fetal hypoxia. Others say that *in utero* defecation is a vagal response caused by transient cord compression. Whatever the reason for meconium passage *in utero,* it is frequently accompanied by fetal gasping and uncoordinated swallowing, resulting in aspiration of some of the meconium-containing amniotic fluid. The sequelae of meconium aspiration may be pulmonary atelectasis with hypoxemia, ball-valve type of air trapping with hypercarbia leading to acidosis, neonatal respiratory distress, right to left shunting, pneumothorax, and all too frequently, death.

New information is available on managing deliveries with meconium-stained amniotic fluid and immediate care of the neonate. The information is convincing that neonatal meconium aspiration is a preventable disease, and that neonatal mortality and morbidity can be reduced to virtually zero by early efficient pharyngeal and tracheal suction of neonates.

A study comparing the results of neonatal tracheal suction with no tracheal suction showed striking differences in survival and symptomatic problems.[2] The study comprised one group treated by *tracheal suction* (immediate laryngoscopy and airway suction with a #10 catheter or endotracheal tube prior to stimulation or positive pressure oxygen) and another group with *no tracheal suction* with only bulb suction of mouth and pharynx and stimulation. The neonatal outcome of these meconium-stained infants was strikingly different. In the group that received *tracheal suction,* 70% were asymptomatic and there was only one death. In contrast, the *no tracheal suction* group had only 40% asymptomatic and 25% deaths. In 1974 a protocol utilizing nasopharyngeal suctioning was initiated in Denver by Carson and coworkers.[3] The obstetrician used a De Lee suction trap as soon as the head was delivered, and then the pediatrician looked at the cords and suctioned the trachea if meconium was present. This combined approach resulted in a five-to-sixfold decrease in symptomatic neonatal meconium aspiration syndrome and no deaths from it in their hospital, compared to the higher incidence in the previous period.

Two studies suggest that neonates born in amniotic fluid that is dark green, black, tenacious or particulate are more apt to suffer symptomatic meconium aspiration than if the amniotic fluid is only slightly and/or recently tinged with meconium. A California group suctioned the tracheae of 80 successive meconium-stained neonates.[4] The relationship between the type of meconium and a well neonate or one with symptomatic respiratory symptoms (sick) was: no meconium (3% sick); thin tracheal meconium (22% sick); thick ('peasoup') tracheal meconium (53% sick). The conclusion of that study was "all infants born through thick, particulate, or 'peasoup' meconium should have their trachea aspirated immediately after birth."[4]

Recently 545 high-risk meconium-stained amniotic fluid deliveries were studied by Meis et al.[5] They were divided into LATE passage (in the second stage of labor after clear amniotic fluid) and EARLY passage (noted at rupture of membranes). The EARLY passage was subdivided further into [a] Light — which was light yellow or greenish stain

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and [b] Heavy — which was darkly stained, dark green or black, usually thick and tenacious. The EARLY-Heavy had significantly [a] more asphyxiated neonates (low APGAR at 1 and 5 minutes), [b] the highest incidence of neonatal meconium aspiration syndrome (11-fold higher than EARLY-Light), [c] more evidence of fetal distress (tachycardia and loss of baseline variability in monitored patients) and [d] more fetal and neonatal deaths compared to the other stained groups or a control population without staining. Of additional interest was that the LATE passage had a higher incidence of meconium aspiration syndrome than the EARLY-Light group.

In light of this newer information, a rational approach to the meconium-stained infant (especially the 'peasoup', dark, thick, EARLY-Heavy type) should include:

[a] Suction of oronasal pharynx with a bulb or De Lee suction trap immediately after birth of the head — (before the first extrauterine gasp is clearly best).

[b] As soon as possible after birth visualize the neonate's vocal cords and administer tracheal suction if meconium is seen — or if the baby is obviously symptomatic (suction might have to be done more than once until no more meconium is obtained).

[c] Administer oxygen as needed.

[d] Suction the stomach with an oral-gastric tube since the stomach contents might also contain meconium that might later be vomited and aspirated.

[e] Close observation and symptomatic support in the nursery (be alert for possible pneumothorax).

[f] Consultation for persistent problems.

The plan suggested here must obviously be used in conjunction with many other medical decisions and considerations at the same time; for example, how severely depressed the baby is and how long one attempts intubation to aspirate meconium versus giving positive pressure oxygen for resuscitation, the condition of the mother, personnel available, and so forth. Given all these considerations it seems reasonable to expect that Wisconsin physicians engaged in perinatal care should play an active role in the prevention of meconium aspiration syndrome, a serious neonatal disease!

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Abstracts

Intestinal strangulation in germfree and monocontaminated dogs

CHARLES E. YALE, MD, DSc; EDWARD BALISH, PhD, University of Wisconsin Medical School, Madison, Wis: *Arch Surg* 114:445-448 (Apr) 1979

Earlier studies in the germfree rat demonstrated that the common intestinal bacteria vary greatly in their ability to cause death after intestinal strangulation. Some of these experiments were repeated in adult, germfree and monocontaminated beagles. Neither short closed-loop hemorrhagic nor long closed-loop ischemic strangulation killed the germfree dog. Either procedure rapidly killed the dog with a conventional bacterial flora or a dog monocontaminated with *Clostridium perfringens*. The dogs monocontaminated with *Bacteroides fragilis* died after several days, whereas *Escherichia coli* killed only one of three animals. These experiments demonstrate the usefulness of the germfree dog as a unique research subject, confirm our earlier studies on intestinal strangulation in germfree rats, and further emphasize the differing lethal potentials of the intestinal bacteria in intestinal strangulation. (Read before the 86th annual meeting of the Western Surgical Association, Scottsdale, Ariz, Nov 15, 1978.) ■

Mucormycosis: a complication of critical care

WILLIAM A AGGER, MD and DENNIS G MAKI, MD, Univ of Wisconsin Center for Health Sciences, Madison, Wis: *Arch Intern Med* 138:925-927, 1978

Lethal nosocomial mucormycosis developed in three previously well individuals while they were receiving intensive care for acute hemorrhagic pancreatitis, for cardiogenic shock, and for a ruptured intra-abdominal aortic aneurysm. In two cases, the condition was first seen as progressive cavitary pneumonia refractory to antibacterial therapy; Mucoraceae was identified in all three patients only at autopsy. Each patient had received large doses of corticosteroids and broad-spectrum antibiotics, and all had suffered from respiratory failure, acute renal failure with acidosis, and severe hyperglycemia in association with total parenteral nutrition. Mucoraceae should be regarded as an additional nosocomial pathogen in the setting of advanced life-support care. ■

Book Review

Chemosurgery: Microscopically controlled surgery for skin cancer

FREDERIC E MOHS, BSc, MD, Dept of Surgery and Wisconsin Clinical Cancer Center, University Hospitals, Madison, Wis. Charles C Thomas, Springfield, Ill, 1978, pp 378

In his new book, Doctor Mohs describes in detail the chemosurgical techniques he has developed for treating cancers of the skin, body orifices, and accessible body structures; various noncancerous growths; infections; and gangrene.

Chemosurgery, using the fixed tissue method, permits microscopically controlled surgery of tissues fixed in situ by chemical means. It is the method of choice for advanced, complicated cancers because the source of the excised specimens can be accurately marked on the incisional surface and the fixative prevents spreading of cancer cells over the wound surface. Chemosurgery can be used for most cancers on the external body surface and many cancers in cavities accessible through normal, artificial, or pathologic openings. Therefore most carcinomas, melanomas, and sarcomas of the skin and neoplasms of the lips, oral cavity, salivary glands, nasal cavities, accessory sinuses, larynx, vulva, vagina, penis, and anus can be treated. It can sometimes be useful in certain cases of breast cancer, especially local recurrences. Because cancers of various regions of the body have individual characteristics and responses to treatment, chemosurgery of each area is discussed in detail. About 250 figures show the appearance of the lesions before, during, and after treatment.

A modification of the method in which fresh tissue is excised and frozen sections of the removed tissue are studied microscopically eliminates the discomfort produced by penetration of the fixative. It permits sparing of tissue in some anatomic sites and often immediate closure of defects following removal of the primary cancer. However it should only be used if the cancer is not too extensive. Care must be taken to avoid disseminating carcinoma cells over the incisional surface.

The reliability of chemosurgery for treatment of skin cancer has been unprecedented. The 5-year cure rate using the fixed tissue technique is 99.3% for basal cell carcinoma and 94% for squamous cell carcinoma. With the fresh tissue technique successful results were achieved in 99.8% of the patients, although all are not 5-year end results.

The method also permits conservation of maximal amounts of normal tissues, facilitates satisfactory reconstruction, and permits the selective following of the unpredictable outgrowths from the main mass of the tumor. The operative risk is low because there is no need for general anesthesia. There are few complications from infection and little breakdown of the wounds. Consequently surgery is possible for many otherwise inoperable patients. Patients can be ambulatory, so there is little danger of pulmonary, circulatory, or embolic complications. Often healing by granulation yields good results, but repair of a defect can be done immediately after a microscopically cancer-free plane is reached without fear of disseminating the neoplasm. Also residual foci of cancer can be easily observed at an early date. Often the procedure can be done without hospitalization, so it is economical of both time and money.

Chemosurgery has permitted detailed observations on those silent extensions of a neoplasm which appear to be formed by differing mechanical and nutritive conditions in the tissues that affect cancer growth. Extensions are sometimes confined to one type of tissue such as the dermis, fascial planes, periosteum, perichondrium, embryologic fusion planes, nerve sheaths, lymphatic vessels, or blood vessels.

The management of nonmalignant growths by nonchemosurgical techniques, such as the use of dichloroacetic acid, curettage, or topical 5-fluorouracil is also described. Treatment of benign epithelial, connective tissue, vascular, pigmented, and infectious growths is described, as well as the palliative treatment of infected inoperable cancers and gangrene of the extremities.

This book should be of value to dermatologists, plastic surgeons, general surgeons, otolaryngologists, ophthalmologists, gynecologists, urologists, pathologists, radiotherapists, internists, and general practitioners. Chemosurgery requires a detailed knowledge of the anatomy of the affected areas and the natural history of disease; involves teamwork with physicians in many fields of specialty; and it especially requires manual dexterity, meticulous care, good surgical judgment, and persistence during long periods of sustained effort which are required when treating advanced cancers. Although the techniques are described in sufficient detail that one could learn how to do the methods from reading the book, it is recommended that a physician obtain special training. However, to help interested physicians the establishment of a chemosurgery clinic, floor plans, necessary equipment, preparation of solutions, and personnel are discussed.

DOROTHY J BUCHANAN-DAVIDSON, PhD
Science Writer, WCCC ■

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Organizational SMS

Society points out problems in medical records bill

"While some technical problems still exist in the proposal, the State Medical Society supports the concept of patient access to medical records and the basic objectives of Senate Bill 260," SMS Physicians Alliance Director Brian Jensen told members of the Assembly Health and Social Services Committee in December. Jensen was testifying at a hearing on SB 260 which would recodify the rules in the statutes pertaining to patient access and confidentiality of medical records in Wisconsin.

Jensen asked that three problem areas in the bill be resolved. Presently, the bill would allow a patient to receive x-ray films and x-ray reports done by radiologists only, thereby not permitting a patient to obtain his/her x-ray report from another type of physician or from chiropractors, dentists, or podiatrists. SMS recommended that the language be changed to allow patient access to x-ray films from "any health care provider" who has performed the service.

In cases of psychiatric patients, the bill would allow a physician to restrict patient access to records during treatment when the physician feels that access could cause further psychological damage to the patient. Under the proposed language, however, the physician must first obtain a second opinion from a physician who is not on the same hospital medical staff.

"There is no reason for using hospital medical staff privileges as criteria in this matter," Jensen said, "furthermore, it suggests some sort of collusion on the part of physicians, which is absurd."

"Since psychiatrists frequently serve on multiple hospital staffs, it would in many instances force a psychiatrist to seek second opinions from psychiatrists long distances away," he said in recommending deletion of the hospital staff restriction.

Jensen urged the Committee to keep exceptions to the general confidentiality portion of the bill at a minimum. The bill would set up general confidentiality statutes forbidding release of medical records without the patient's consent, except in certain instances.

"Rather than listing some of these proposed exceptions in the statutes, they should be included in preadmission statements used by some hospitals," he said.

The Assembly Committee reacted favorably to the Society's suggestions and it now appears that they may be incorporated into the final bill draft. ▪

WMJ subscription rates change

Effective Jan 1, 1980 the following rates apply for annual subscriptions to the *Wisconsin Medical Journal:*

Members: $10.00 (included in dues).
Nonmembers: $20.00.
Libraries: $12.00.
Foreign and Canada: $25.00.
Single copy (current year): $2.00.
Single copy (previous years): $3.00.
Blue Book issue: $7.00. ▪

Agreement reached on x-ray bill

A special committee of the SMS Commission on Governmental Affairs, working with key legislators, reached an agreement in December on substitute language for a bill (AB 824) calling for certification of all x-ray machine operators in Wisconsin.

The Committee, consisting of physicians, dentists, and radiologic technologists, in December drafted the alternative proposal and presented it to the bill's author, Rep David Travis (D-Madison) and Rep Joseph Czerwinski (D-Milwaukee), chairman of the Assembly Committee on Health and Social Services.

The SMS Commission on Governmental Affairs approved the substitute language in November.

The new language eliminates a provision calling for a "Super Committee" of consumers, chiropractors, dentists, nurses, and physicians to recommend x-ray certification rule development. In its place, the individual examining boards would develop minimum x-ray certification standards and the Medical Examining Board would develop the standards for physicians and persons working for physicians.

Also deleted was a requirement that anyone, including physicians, who operates an x-ray machine first pass an x-ray proficiency test.

A major provision in the substitute sought by the State Medical Society, calls for increased emphasis on inspection of x-ray machines and facilities by the Dept of Health and Social Services. The bill was introduced to the Joint Finance Committee of the State Legislature in late December. Committee action is expected in January. ▪

WMJ staff changes

SMS Secretary Earl Thayer has announced the promotion of Mrs Mary Angell to managing editor of the *Wisconsin Medical Journal,* the official publication of the State Medical Society of Wisconsin. Mrs Angell has been a member of the WMJ staff for 21 years, having served as assistant managing editor for the past 17 years under the direction of Mr Thayer, who as secretary traditionally had served as managing editor.

In another move to strengthen the WMJ staff capability, Mrs Diane Upton was named editorial assistant. Mrs. Upton joined the SMS in 1977 in the Communications Department, later being named communications coordinator. Among her present duties is publication of MEDIGRAM, the semimonthly newsletter to SMS members. Mrs Upton will continue to report the organizational news in WMJ as well as assisting in other assignments.

Mrs Marjorie Stafford, who has been on the WMJ staff for 13 years, continues as publications assistant. Mrs Stafford also assists with the SMS Placement Service, a membership benefit. ■

CONTRIBUTIONS CES FOUNDATION NOVEMBER 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November 1979.

Restricted

CB Moen, MD; Indianhead Chapter, Wisconsin Academy of Family Physicians—*Medical Student Summer Externship Program*

John T McEnery, MD; Mrs Loren J Driscoll—*Aesculapian Society*

Memorials

Dee Miller—*Harold May (Student Loans)*

Ruth May—*Harold May*

Dr-Mrs Donald Rowe—*Dorothy Dobbs (Nursing & Allied Medical Careers—Sheboygan County Auxiliary Loan Fund)*

Dr-Mrs EJ Nordby—*Mrs Meta Zuege*

Dr-Mrs EJ Nordby; Joan Pyre; Mr-Mrs Earl R Thayer—*Jean Anderson*

Dane County Medical Society; State Medical Society—*R H Wasserburger, MD*

State Medical Society—*W Andreas Sannes, MD; Ralph B Lenz, MD; Ralph L Troup, MD*

Governor vetoes bill prohibiting fee for filing claim forms

Governor Lee Dreyfus, December 5, vetoed AB 243 which would have prohibited the charging of a fee for the completion of health insurance claim forms. In his veto message, the Governor applauded the attempt at curbing healthcare costs, but felt that AB 243 does not accomplish that task. The Governor called on the State Medical Society to examine the issue and recommend methods of addressing the problem.

The State Medical Society, in testimony before the Senate Insurance & Utilities Committee, informed the Committee of its position that no charge should be made for the completion of the primary "simplified" claim forms used to enable the patient to receive his or her benefits. Increased paperwork being generated by a rapidly growing third-party payment system and a lack of uniform claim procedures are factors in rising healthcare costs to both provider and consumer.

The Society continued by suggesting that the State of Wisconsin consider a Uniform Claim Form to be used statewide for health insurance claims as a first step in alleviating this costly problem.

AB 243 overwhelmingly passed the State Assembly and passed the Senate on a voice vote. The Legislature will have an opportunity to override the Governor's veto in 1980 by garnering a two-thirds vote in both Houses. ■

Data released on health insurance benefits

Private health insurance companies nationwide paid $43.1 billion in benefits in 1977 while taking in nearly $44.5 billion in premiums the same year according to recent data published by the Health Insurance Institute. "The Source Book of Health Insurance Data 1978-79" shows that $875 million in benefits were paid in Wisconsin in 1977 by private insurance companies, Blue Cross-Blue Shield and other hospital medical plans while premium income amounted to $1,109 million. In 1977, $402.8 million in *Medicare* benefits were paid by the State of Wisconsin to 581,600 persons and $485.3 million in *Medicaid* benefits were paid to 485,300 persons. The average charge of semi-private hospital room in Wisconsin went from $71.68 in July 1976 to $90.33 in July 1977—an increase of about 25 percent. The book listed 6,513 physicians in active practice in Wisconsin in 1977 at a rate of 140 physicians per 100,000 population. ■

SMS Annual Meeting set

Plans have been completed for the 1980 Annual Meeting of the State Medical Society to be held Thursday, Friday, and Saturday, March 27, 28, and 29, in Milwaukee at MECCA and the Marc Plaza Hotel. Details appear elsewhere in this issue. Summaries of resolutions to be presented to the House of Delegates will appear in the February issue. ■

Governor Dreyfus to speak at Annual Meeting dinner

SMS President Darold A Treffert, MD, Fond du Lac, and President-elect Russell F Lewis, MD, Marshfield, have announced that Wisconsin Governor Lee Sherman Dreyfus will be the featured speaker at the Presidents' Dinner and Reception, Friday, March 28, during the 1980 Annual Meeting of the State Medical Society in Milwaukee. All SMS members and their spouses are invited to attend. Ticket orders for this and all other Annual Meeting events will be contained in the Annual Meeting Program to be mailed to physicians shortly.

Highlights of the Annual Meeting program and biographical sketches of the nominees for offices of the SMS can be found elsewhere in this issue. ■

OFFICIAL NOTICE: To members of the State Medical Society of Wisconsin Proposed constitutional amendments affecting Unified Membership rule up for vote by the House of Delegates on March 28, 1980

ARTICLE XIII of the Constitution of the State Medical Society of Wisconsin provides: "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken."

At the May 1979 Annual Meeting, two resolutions were introduced proposing amendment of Article IV of the Constitution—the socalled Unified Membership rule.

As to Resolution 1, introduced by the Council, the House accepted the report of its Reference Committee on Resolutions and Amendments to the Constitution and Bylaws "that the amendment has been introduced in timely fashion, and consistent with Article XIII of the Constitution it will lie over as presented for consideration and vote at the 1980 annual session." Resolution 1 read as follows:

> RESOLVED: That the Council of the State Medical Society of Wisconsin introduce to the 1979 House of Delegates a recommended amendment of the Constitution, pursuant to Article XIII thereof, to delete from Article IV wording which mandates membership in the American Medical Association, such Article then to read as follows:
>
> "The Society shall consist of members who shall be the members of the component county medical societies, who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary."

As to Resolution 4, introduced by the Board of Directors of the Medical Society of Milwaukee County, the House accepted the report from the reference committee noting that the proposed amendment to Article IV "additionally strikes the clause 'who shall be members of the component medical societies.' The reference committee was not clear as to the exact intent of the amendment. The committee reports that the proposed amendment has been introduced in timely fashion, and consistent with Article XIII of the Constitution it will lie over as presented for consideration and action at the 1980 annual session." Resolution 4 read as follows:

> *Whereas,* Recent membership opinion surveys by both the State Medical Society and the Medical Society of Milwaukee County indicate that a majority of responding members are opposed to the current "unified membership" requirement contained in the State Medical Society Constitution, and
>
> *Whereas,* The Milwaukee Board of Directors is obliged to make known the wishes of its members who comprise a significant percentage of the total SMS membership, now be it therefore
>
> RESOLVED, That the House of Delegates is urged to adopt an amendment (by deletion of certain wording) in Article IV of the SMS Constitution as follows:
>
> "This Society shall consist of members (who shall be members of the component medical societies, and who shall also be members in good standing of the American Medical Association, and) who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the Society."
>
> RESOLVED, That adoption of this amendment by the House will manifest that individual members still have a voice in determining the policies of their State Medical Society, and that their elected representatives in the House are responsive to the will of the majority. ■

(Published in the January and February 1980 issues of the *Wisconsin Medical Journal.*)

Obituaries

◊ County, State, AMA Members

◊ **Evan Bowen Davies, MD,** 75, Waukesha, died Oct 17, 1979 in Waukesha. Born Aug 20, 1904 in Waukesha County, Doctor Davies graduated from Northwestern University School of Medicine in 1936. He had practiced in the Waukesha area until his retirement in 1968. Surviving are three sons, Dr William B, Dr Robert E, and Douglas A all of Waukesha, and a daughter, Mrs Richard (Elizabeth) Marlow of Waukesha.

◊ **Otto A Mortensen, MD,** 77, emeritus professor of anatomy at the University of Wisconsin Medical School, Madison, died October 18, 1979 in Menlow Park, Calif. Born June 4, 1902 in Milwaukee, Doctor Mortensen graduated from the University of Wisconsin Medical School, Madison, in 1929. He served as associate dean of the UW Medical School from 1948-1967 and continued to teach until he retired in 1972. Since his retirement he had served as visiting professor of anatomy at Stanford University School of Medicine, Palo Alto, Calif. In 1967, Doctor Mortensen received the "Distinguished Service Award" for teaching and administration from the State Medical Society of Wisconsin. Surviving are his widow, Lila, and three children.

◊ **Howard F Schloemer, MD,** 68, Menomonee Falls, died Oct 19, 1979 in Menomonee Falls. Born Feb 23, 1911 in West Bend, Doctor Schloemer graduated from the University of Illinois Medical School in 1948. He had practiced medicine in the Menomonee Falls area for 30 years and was on the medical staff of St Joseph's Hospital in Milwaukee and also the Community Memorial Hospital of Menomonee Falls. In 1971, he served as chief-of-staff of Community Memorial Hospital. Surviving are his widow, Genevieve; three daughters, Mrs Karen Smith, Glenview, Ill; Mrs Kristine de Karske, Waukesha, and Mrs Karolyn West of Menomonee Falls; and one son, John of Sheboygan.

◊ **George James Kelm, MD,** 69, Muskego, died Nov 1, 1979 in Milwaukee. Born Oct 28, 1910 in Milwaukee, Doctor Kelm graduated from Marquette University School of Medicine in 1936. He had practiced medicine in the Muskego area for 40 years until his retirement in 1978. Doctor Kelm served on the medical staff of Waukesha Memorial Hospital. Surviving is his widow, Violet.

Nathaniel O Calloway, MD, 72, Madison, died Nov 5, 1979 in Madison. Born Oct 10, 1907 in Alabama, Doctor Calloway graduated from the University of Illinois Medical School, Chicago, in 1943. He taught medicine at the University of Illinois from 1946-1958. In 1963, he joined the medical staff of the Veterans Administration Hospital, Tomah, and in 1966 he opened his medical practice in Madison. Surviving are his widow, Mary Ann; five daughters and two sons.

◊ **James W MacGregor, MD,** 82, Portage, died Nov 1, 1979 in Portage. Born Sept 20, 1897 in Nekoosa, Doctor MacGregor graduated from Northwestern University Medical School, Chicago, in 1922. He had been in medical practice in Portage since 1923 and was honored by the State Medical Society of Wisconsin in 1972 for his 50 years of practice. He had served as chief of staff of Divine Savior Hospital, Portage, and also was a veteran of World Wars I and II. Surviving are a son, James of Baltimore, Md, and a daughter, Mrs Jenny Polacek of Wauwatosa.

◊ **Lillian M Thomas, MD,** 51, Greenfield, died Nov 17, 1979 in Greenfield. Born Feb 17, 1928 in Canonsburg, Pa, Doctor Thomas graduated from Marquette University School of Medicine in 1951 and served her residency in pediatrics at Milwaukee Children's Hospital. She was on the medical staff of Milwaukee Children's, St Mary's and St Francis hospitals. She was a past president of the Milwaukee Academy of Pediatrics. Surviving is a daughter, Mary Alice Wagner.■

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County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

CLARK: Mike Brozek, legislative coordinator, and Rick Reas, research analyst, of the SMS Physicians Alliance Division spoke to nine members of the Clark County Medical Society at its November meeting in Loyal. The subject was an update of the SuperRule and Provider Agreement.—**A Mitat Algan, MD,** Neillsville, Secretary

POLK: John Simenstad, MD* of Osceola addressed 12 members of the Polk County Medical Society at its November meeting on "Medicine in Russia."—**Marwood E Wegner, MD,** St Croix Falls, Secretary

WINNEBAGO: Kenneth Viste, MD* of Oshkosh spoke to 56 members of the Winnebago County Medical Society at its November meeting on "Russia Today." Doctor Viste participated in a People-to-People goodwill tour to Sweden, the Soviet Union, and Switzerland last summer.—**Charles Lyons, MD,** Oshkosh, Secretary

WINNEBAGO: Dr David Chang of the political science department at the University of Wisconsin-Oshkosh addressed the Winnebago County Medical Society on the topic, "Medicine and Politics in China Today." Kenneth Viste Jr, MD,* Oshkosh, reported on the "Super-Rule." Members were invited to attend a reception for Barbara Bush, wife of George Bush, at the George Arndt, MD* home in Neenah on January 14. There were 46 members and three guests present at the January 3 meeting in Oshkosh. The February 7 meeting will be held in Menasha and will feature "Meet Your Politicians."—**Charles Lyons, MD,** Oshkosh, Secretary

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WOOD: Speakers at the Wood County Medical Society October meeting were Jung K Park, MD,* Wisconsin Rapids, and Russell F Lewis, MD,* Marshfield. Doctor Park, a State Medical Society councilor, reported on activities at the state level while Doctor Lewis, president-elect of the SMS, spoke about progress being made in organized medicine. There were 131 persons attending, including spouses and guests.—**Homer H Russ, MD,** Marshfield, Secretary

WOOD: At its December meeting the Wood County Medical Society elected the following officers: MDs Charles Wood,* Wisconsin Rapids, president; Robert Heywood,* Marshfield, vice-president; and Richard Leer,* Marshfield, secretary-treasurer. MDs Raymond Hansen,* Marshfield; Charles Sorensen,* Wisconsin Rapids; and John Thompson,* Nekoosa, were elected to serve as delegates or alternate delegates to the SMS House of Delegates.

Darold A Treffert, MD,* SMS president, Fond du Lac, gave an inspirational address entitled, "Faster Horses, Younger Women, Older Whiskey, More Money." Michael Mehr, MD,* Marshfield, reported on activities of WISPAC and encouraged individual membership. —**Homer H Russ, MD,** Marshfield, Secretary ■

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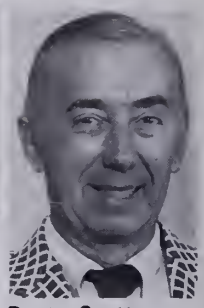


Doctor Scott

ANNUAL MEETING

Nominees awaiting the vote

Here is a complete list of those candidates chosen for top State Medical Society offices by the Committee on Nominations. This is the slate on which the House of Delegates will vote at the Society's Annual Meeting March 27-29 at Milwaukee's Exposition and Convention Center and Arena (MECCA) and Marc Plaza Hotel. Be sure to let your county medical society delegate know your preferences in the next few weeks.

☐ Albert J Motzel Jr, MD

President-elect of State Medical Society (1980-81)

Graduate of St Louis University Medical School. Served internship at Milwaukee County Hospital in 1953-54 and residency in surgery at Milwaukee County Hospital in 1954-1958. Received license to practice medicine in Wisconsin in 1954. Has been in practice of general surgery in Waukesha since 1958. Has been a diplomate of the American Board of Surgery since 1959. Is clinical instructor in surgery at Medical College of Wisconsin. Is on active staff of Waukesha Memorial Hospital, Waukesha, and on associate attending staff of Milwaukee County Hospital, Milwaukee. Is Director of Medical Education and coordinator of Medical Staff Affairs at Waukesha Memorial Hospital. Was president of Waukesha County Medical Society in 1972-1973. Has served as delegate from Waukesha County Medical Society to State Medical Society. Is a member of the Wisconsin Surgical Society, Milwaukee Academy of Surgery, Society for Computer Medicine, Association for Hospital Medical Education, and a member of the American Academy of Medical Directors. Is a fellow of the American College of Surgeons. Former director and vice-president of Board of Directors of Foundation for Medical Care Evaluation of Southeastern Wisconsin. Served 1975-1976 as House vice-speaker and House speaker from 1977 to present.

EDITOR'S NOTE: Doctor Motzel, currently Speaker of the House of Delegates, is nominated for President-elect and Doctors Taebel and Erwin are both nominated for Vice-speaker. The H/D Nominating Committee; in its minutes, provided that: "If Doctor Motzel is elected to the office of President-elect and then resigns his Speaker position, Dr Duane Taebel will be nominated for Speaker of the House and Dr Chesley Erwin for Vice-speaker of the House." AMA Delegates Scott, Stuff, and Williams are nominated to succeed themselves. AMA Alternate Delegates Edwards, Natoli, and Riesch are nominated to succeed themselves.

☐ Patricia J Stuff, MD

Delegate to American Medical Association (1981-82)

Graduate of Woman's Medical College. Received internship at St Luke's Hospital, Chicago, Ill, 1955 to 1956. Served residency at Sacred Heart Hospital, Yankton, SD, 1956 to 1957. Received license to practice medicine in Wisconsin in 1957. Began general practice of medicine in Bonduel same year. Has been delegate to State Medical Society of Wisconsin from Shawano County Medical Society, 1966-1973 and alternate delegate in 1977-1978. Became vice-speaker of House of Delegates in 1973. Also has served as member of State Medical Society's Nominating Committee and of House of Delegates reference committees. Member of board of directors of Wolf River Mental Health Clinic, founded by citizens' committee she organized in 1964. Headed clinic's board of directors in 1966. Served as vice-chairman of Unified Mental Health Board of Shawano and Waupaca counties and chairman of its planning committee 1974-1975. Is chairman of credentials committee of Shawano Community Hospital. Was recipient of "Woman of the Year" award by Shawano County Business and Professional Women's Association in 1971 and is listed in *Who's Who of American Women*. Serves as Adjunct Professor, University of Wisconsin-Oshkosh, 1975 to present. Member of SMS Ad Hoc Committee on Women's Health Issues, 1979, chief teller at 1979 AMA Annual Meeting, and appointed to chair AMA Ad Hoc Committee on Women Physicians in Organized Medicine, September 1979.

☐ John Kimball Scott, MD

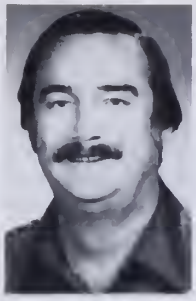
Delegate to American Medical Association (1981-82)

Graduate of Ohio State University College of Medicine, 1954. Internship, White Cross Hospital, Colum-

Doctor Erwin

Doctor Taebel

Doctor Williams


Doctor Edwards

Doctor Natoli

Doctor Riesch

bus, Ohio, 1954-55; otolaryngology residency at University Hospitals, Columbus, Ohio, 1955-58. Licensed to practice medicine in Wisconsin, 1958. Certified by American Board of Otolaryngology, 1959. Clinical Professor of Otolaryngology at University of Wisconsin Medical School. On staffs of St Mary's, Madison General, and University hospitals, Madison. Preceptor for fourth year residency program, Madison General Hospital. President, Dane County Medical Society, 1975. Delegate from Dane County Medical Society to the State Medical Society of Wisconsin, 1972-present. Alternate delegate to the AMA, 1977-78; delegate to the AMA, 1979-80. Member, State Medical Society Reference Committee, 1971-72; Reference Committee Chairman, 1972 and 1973. State Medical Society Committee on Cancer, Chairman since 1971. Member, SMS Committee on Medicine and Religion. Secretary-Treasurer of WISPAC. National delegate to American Cancer Society since 1972; President, ACS, Wisconsin Division, 1972. President of Wisconsin Otolaryngology Society, 1974. Fellow, American College of Surgeons, 1962. President, Wisconsin Chapter of the American College of Surgeons, 1978-79. Member, American Academy of Ophthalmology and Otolaryngology since 1960. Chairman of Commission on Cancer, Wisconsin Chapter of American College of Surgeons. Member, Society of Head and Neck Surgeons, 1963. Member, American Laryngological, Rhinological and Otological Society, 1972. Chairman of Board, WisPRO. Team physician for sports, West High School, Madison.

☐ Chesley P Erwin, MD

Vice-speaker of House of Delegates (1980-81)

Graduated from the School of Medicine, University of Oklahoma in 1951. Interned at Harris Hospital, Fort Worth, Tex from 1951-52 and residency in pathology at Milwaukee County General Hospital, 1952-55 and Lutheran Hospital, Milwaukee, 1955-56. Served in the United States Armed Forces, 1942-46. Board certified in Anatomic and Clinical Pathology in 1956; certified in subspecialty in Forensic Pathology in 1976. Is professor of pathology at the Medical College of Wisconsin, and also is medical examiner of Milwaukee County serving from 1972 to the present. Is fellow of College of American Pathologists, American Society of Clinical Pathologists, and the American Academy of Forensic Sciences. Is member of the International Academy of Pathology, International Association of Coroners and Medical Examiners, New York Academy of Sciences, Milwaukee Academy of Medicine, American Association for the Advancement of Sciences, Wisconsin Coroners Association, Wisconsin Society of Pathologists, and National Association of Medical Examiners. Served as president of the Medical Society of Milwaukee County, 1976; president of the Wisconsin Society of Pathologists, 1971-73; and president, Faculty Assembly, Medical College of Wisconsin from Nov 1970 (inception) until July 1971. Is member of Council and president-elect of Milwaukee Academy of Medicine; member, Board of Directors, Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc; delegate from Milwaukee county to State Medical Society of Wisconsin; member, Health Plan Committee, Health Systems Agency of Southeastern Wisconsin; member, operating Committee, Milwaukee Health Protection Plan; member, University of Wisconsin System Medical Technology Advisory Committee; and vice-chairman of WISPAC, 1979-1981. Served on the medical staff of Family Hospital, Milwaukee, from 1956-66 and presently is on the staff of Milwaukee County General Hospital, 1966 to present.

☐ Duane W Taebel, MD

Vice-speaker of the House of Delegates (1980-81)

Graduate of University of Chicago School of Medicine, 1960. Internship at University of Chicago Hospital, 1960-61. Internal medicine residency at University of Chicago Hospital, 1961-64 and was chief resident in medicine, 1963-64. Fellow in gastroenterology, 1964-66, and was instructor, Dept of Medicine, University of Chicago Hospital. Served in US Army Hospital. Fort Devens, Mass, 1966-68. Received Wisconsin license in 1966 when joined Gundersen Clinic-LaCrosse Lutheran Hospital. Board certified in internal medicine, 1968, and recertified in 1974. Board certified in gastroenterology, 1972. Was member of American Society of Cytology and Alpha Omega Alpha Honor Medical Fraternity. Holds memberships in American Gastroenterology Association and American Society of Gastrointestinal Endoscopy. Is Fellow, American College of Physicians. Is chairman of the Department of Medicine, Gundersen Clinic, Ltd, and has served as chief-of-staff, LaCrosse Lutheran Hospi-

tal. Was president of LaCrosse County Medical Society, 1976. Has been delegate to State Medical Society since 1972 and vice-speaker of the House of Delegates in 1978. Was member of SMS ad hoc committee on redistricting. Serves on Board of Control of Wisconsin Professional Standards Review Organization (WisPRO), 1975 to present. Also is on the WisPRO West Central District Review Council.

□ DeLore Williams, MD

Delegate to American Medical Association (1981-82)

Graduate of the former Marquette University School of Medicine. Received internship at Milwaukee's Columbia Hospital, 1948-49. Did residency at VA Hospital, Milwaukee, 1949-51 and 1953-54. Received license to practice medicine in Wisconsin, 1949. Before completing residency, served in the US Air Force. In 1957 was certified by American Board of Internal Medicine. Practices in West Allis and is clinical instructor at Medical College of Wisconsin. Was chairman of SMS Ad Hoc Committee on Quackery. Served as 12th District and 1st District SMS Councilor, 1971-77. Served on former Commission on Public Policy as regular member between 1971 and 1972 and as ex officio member between 1973 and 1978. Was member of Council's Finance Committee from 1971 to 1977. Is also member of Wisconsin Society of Internal Medicine, American College of Physicians, and American Society of Internal Medicine. Since 1972 has been delegate to State Medical Society. Elected AMA delegate in 1976 and has served since 1977. Served on his county medical society's Legislative Policy Committee, four of those years as chairman. Also has been active on county's Editorial Board and Medical School Liaison Committee. Served on the County Medical Society Long-range Planning Committee three years. For past nine years has served as member of West Allis Memorial Hospital's Board of Directors. Is member of West Allis Memorial Hospital Finance Committee, Public Relations Committee, Quality Care Committee, and Long Range Planning Committee, and is chairman of its Development Council. Served as member of West Allis Chamber of Commerce Board of Directors from 1962 to 1974 and was president of Chamber of Commerce in 1963. Member of Board of Directors of Central Bank, West Allis, 1973 to present.

Members, Committee on Nominations

Vernon M Griffin, MD, Mauston
Chairman

James J Tydrich, MD, Richland Center
Secretary

District
1 David N Goldstein, MD, Kenosha
John D Riesch, MD, Menomonee Falls
Kenneth M Smigielski, MD, Milwaukee
Jerome J Veranth, MD, Racine
2 Sandra Osborn, MD, Madison
James J Tydrich, MD, Richland Center
3 Vernon M Griffin, MD, Mauston
4 Richard H Ulmer, MD, Marshfield
5 Kenneth M Viste Jr, MD, Oshkosh
6 Gilbert H Stannard Jr, MD, Manitowoc
7 Richard A Henry, MD, Chippewa Falls
8 Joseph M Jauquet, MD, Ashland

Specialty Sections
Joel E Taxman, MD, Milwaukee

□ Richard W Edwards, MD

Alternate Delegate to American Medical Association (1981-82)

Graduated from the University of Wisconsin Medical School, Madison, in 1960, and served a rotating internship at Saint Vincent's Hospital, Toledo, Ohio from 1960-61. Served in the United States Navy from 1950-54 and has been in Family Practice in Richland Center from 1961 to present. Served as president of Richland County Medical Society in 1963 and also as delegate to the State Medical Society of Wisconsin from 1966-69. Is certified by American Board of Family Practice and also a member of the American Academy of Family Physicians. Served as chief-of-staff, Richland Hospital, Richland Center, Wisconsin in 1963, and also was Richland County Coroner from 1966-1978. Served as Councilor of State Medical Society of Wisconsin from 1969-1978 from District II and also was vice-chairman of the SMS Council from 1976-78. He presently is serving as treasurer of SMS (1979-80). He served as chairman of the Finance Committee of SMS Council from 1972-78. From 1969-71, he was a member of the Governor's Special Task Force for Health Manpower for the State of Wisconsin and from 1976-77, he was a member of the Governor's Committee to survey health facilities in the Wisconsin State Prison System. He has been a member of the State Medical Society's Commission on Peer Review since 1969. He served as an instructor at the University of Wisconsin School of Nursing Post Graduate Program for Nurse Practitioners in 1977-78, and has been a participant in the Summer Externship Program for Freshmen Medical Students, sponsored by Wisconsin Academy of Family Physicians since 1970. He presently is an alternate delegate to AMA from Wisconsin serving from 1979-1980.

□ **Cornelius A Natoli, MD**

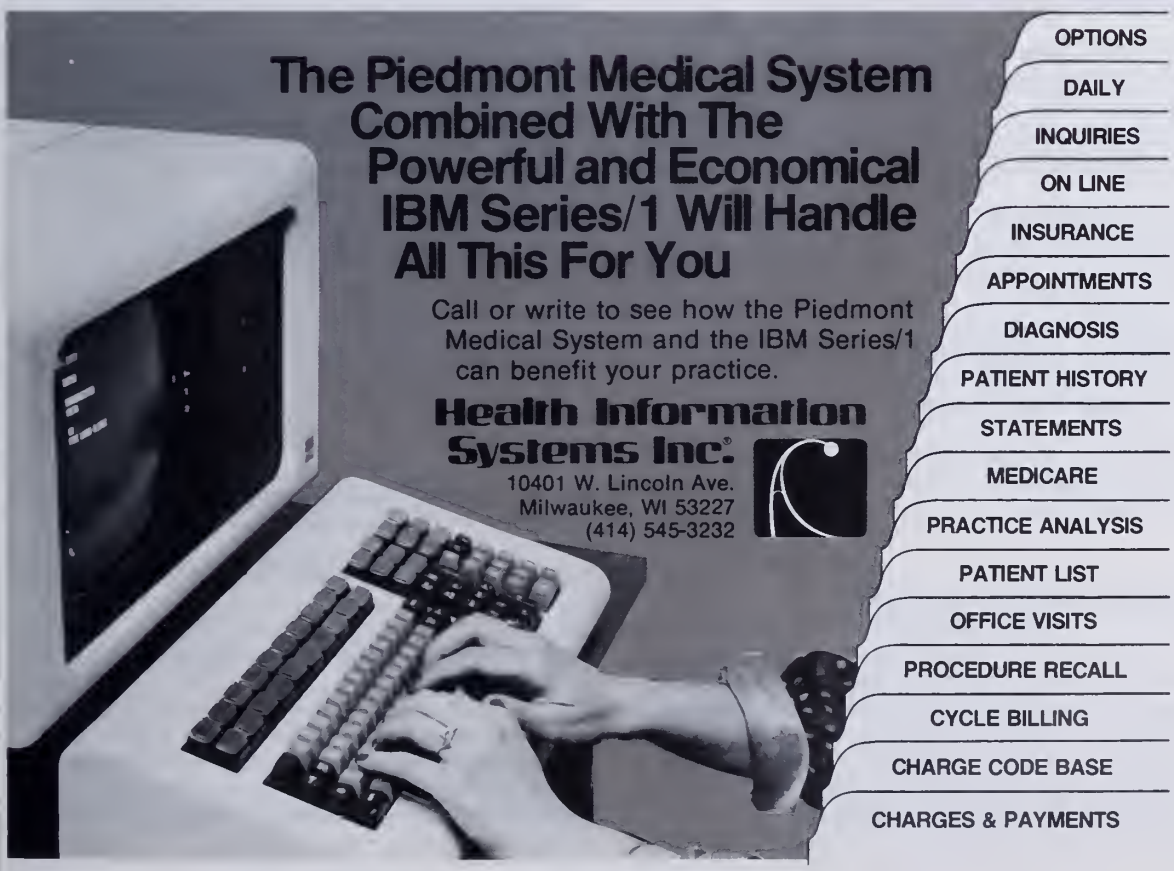
Alternate Delegate to American Medical Association (1981-82)

Born in Utica, New York, 1930, he received BS degree in 1952 from Niagara University, and graduated in 1956 from Georgetown University School of Medicine. Internship and residency in surgery at Barnes Hospital, St Louis, Missouri, followed by three years of urology residency at Barnes Hospital. Private practice in Salt Lake City, Utah, from 1961-1969; held offices in Utah State Medical Association, Public Health Committee, and Utah Urological Society. Member of Gundersen Clinic, Ltd, from 1969 to present. Clinical assistant professor of surgery (urology), University of Wisconsin Medical School. Is past president of LaCrosse County Medical Society; member of American Urological Association, Wisconsin Urological Society, and American College of Surgeons, and North Central Section of AUA. Past chairman LaCrosse County Insurance Advisory Committee; past member of SMS House of Delegates and served on its reference committee on finance and chaired reference committee on reports of officers; member of past SMS Commission on Medical Care Plans and was a member of WPS Board of Directors; past member of SMS House of Delegates Nominating Committee; and served as Third District councilor of SMS. Is a member of WisPAC. Also member of Board of Directors, Gundersen Clinic, Ltd. member of Health Occupation Division Advisory Committee of Western Wisconsin Technical Institute.

□ **John D Riesch, MD**

Alternate Delegate to American Medical Association (1981-82)

Graduate of University of Wisconsin Medical School in 1958. Internship and residency at Milwaukee County General Hospital, 1958 - 1963. Is assistant clinical professor of surgery, Medical College of Wisconsin. Hospital affiliations as a general surgeon: Community Memorial, Menomonee Falls (chief-of-staff, 1969 - 1970; chief of surgery, 1971 - 1972); Elmbrook Memorial, Brookfield; St Joseph's, Hartford (consulting staff); Waukesha Memorial, Waukesha (associate staff); and West Allis Memorial, West Allis. Received Distinguished Alumni Award of Whitewater University, 1972; and became a member of its Hall of Fame, 1973. Served as president of Waukesha County Medical Society in 1973 - 1974; member of Milwaukee Academy of Surgeons; Wisconsin Surgical Society; Milwaukee Medical Society (associate member); American College of Surgeons, president of Waukesha Cancer Society, 1969 -1970, and member of Wisconsin Board of Medical Examiners in 1969. Certified by American Board of Surgery in 1965; received fellowship in American College of Surgeons, 1966. Member of SMS Commission on Mediation and Peer Review and House of Delegates Nominating Committee. Member of Wisconsin Review Foundation. Appointed board examiner for American College of Surgeons, on medical panel of Menomonee Falls Police and Fire Commission, and on disaster committee of Community Memorial Hospital. ■



Annual Meeting

State Medical Society of Wisconsin

PROGRAM HIGHLIGHTS

Scientific Program: Friday-Saturday March 28-29, 1980

House of Delegates Sessions: Thursday-Friday-Saturday March 27-28-29, 1980

Milwaukee Exposition and Convention Center and Arena (MECCA)
500 West Kilbourn Avenue, Milwaukee

Headquarters Hotel: The Marc Plaza
509 West Wisconsin Avenue,
Milwaukee, Phone: 414/271-7250

GENERAL INFORMATION

REGISTRATION. There will be a registration fee of $25 for all physicians who are *nonmembers* of the State Medical Society of Wisconsin payable to the State Medical Society in advance or at the registration desk, first floor, MECCA.

MEAL FUNCTIONS. Advance ticket orders accepted only through March 20. Luncheon tickets: $11; at meeting: $15. Socioeconomic/WISPAC buffet tickets: $12; at meeting: $15.

BUSINESS SESSIONS AND RELATED MEETINGS. At MECCA and The Marc Plaza, with some special affairs elsewhere. Consult the complete program.

SCIENTIFIC PROGRAM COMMITTEE: *Edwin L Overholt, MD,* LaCrosse, Chairman; and *Paul B McAvoy, MD,* cochairman. ■

HOUSE OF DELEGATES

The House of Delegates meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the first session on Thursday afternoon, starting at 2:00. Reference committees will meet Thursday evening at 7:30, with reports to be made at the Friday afternoon session, starting at 4:00. The third session, with election of officers, and installation of the President, will be held on Saturday morning, starting at 8:00. Registration of delegates and alternates precedes the first and second sessions by one hour, the third session by one-half hour. Society members are urged to participate in the discussions on reports and resolutions in the open hearings of the reference committees. A summary of the resolutions will appear in the February issue of *WMJ.* Nominees for Society offices are being announced elsewhere in this issue, with a biographical sketch of each. Delegates and alternates, officers, councilors, and commission/committee chairmen will receive the House of Delegates HANDBOOK containing reports and resolutions to be submitted to the House. These will be discussed at the District Caucuses during February and March, preceding the Annual Meeting.

FIRST SESSION H/D: Thursday, March 27, 1:00 pm registration, 2:00 pm session (MECCA)

SECTION DELEGATES CAUCUS: Thursday, March 27, 10:30 am (MARC PLAZA)

DISTRICT 1 CAUCUS: Thursday, March 27, 1:00 pm; Friday, March 28, 3:00 pm (MECCA)

SECOND SESSION H/D: Friday, March 28, 3:00 pm registration, 4:00 pm session (MECCA)

THIRD SESSION H/D: Saturday, March 29, 7:30 am registration, 8:00 am session (MECCA)

OPEN HEARING AMA DELEGATES: Thursday, March 27, 7:30 pm (MARC PLAZA)

REFERENCE COMMITTEE MEETINGS: Thursday, March 27, 7:30 pm (MARC PLAZA) ■

RELATED EVENTS

COUNCIL MEETING: Saturday, March 29, 10:30 am (MARC PLAZA)

COUNCIL/PAST PRESIDENTS' LUNCHEON: Saturday, March 29, 12:00 noon (MARC PLAZA)

PRESIDENTS' RECEPTION: Friday, March 28, 6:30 pm (MARC PLAZA)

PRESIDENTS' DINNER: Friday, March 28, 7:30 pm (MARC PLAZA)

WISPRO BOARD OF DIRECTORS LUNCHEON/MEETING: Friday, March 28, 12:15 pm (MECCA)

SOCIOECONOMIC/WISPAC LUNCHEON: Friday, March 28, 12:15 pm (MECCA) ■

Special programs/panels—

CPR TRAINING

Thursday, March 27, 8:00 am-12:00 noon
Friday, March 28, 8:00 am-12:00 noon

—A special basic cardiac life support course for physicians, offered by the State Medical Society during the Annual Meeting.
—Registration fee: $50 (enrollment limited to 50 physicians).
—All participants who satisfactorily complete this 8-hour course will receive CPR certification from the American Heart Association. This program qualifies for 8 hours Category I CME credit.
—Study materials and a pretest will be mailed to all registrants in advance of the program, and must be completed prior to attendance.
—Advance registration is required by March 1.

HOSPITAL ACCREDITATION

Thursday, March 27, 12:00 noon-3:00 pm

—A physician's perspective. Sponsored by the State Medical Society of Wisconsin, presented by the Joint Commission on Accreditation of Hospitals.
—Program accredited through the State Medical Society of Wisconsin for 3 hours Category 1 of the AMA-PRA.
—JCAH faculty: F Dimond, MD; D Duncan, MD; Kevin Buckley, Program Manager, Division of Education and Publications.
—I. Medical Staff Privilege Delineation and Reappraisal.
—II. Medical Staff Monitoring Function. A. Surgical Case Review. B. Blood Utilization Review. C. Pharmacy and Therapeutics. D. Antibiotic Usage. E. Medical Record Review.
—III. Quality Assurance Standard.
—IV. Medical Staff Organization, Staff Bylaws, Rules and Regulations (Standard II and III).
—Advance registration required. Registration fee: $10 (includes all materials).

WOMEN IN MEDICINE

Thursday, March 27, 5:30 pm

—Social hour (cash bar) starting at 5:30 pm followed by dinner at 6:30 pm and a featured speaker at 7:30 pm.
—Dual-careers: Myth or Reality, by Alexandra Symonds, MD, New York; Faculty, American Institute of Psychoanalysis-Karen Horney Center; Associate Clinical Professor of Psychiatry, New York University School of Medicine. And Frederick W Coleman, MD, Madison.
—Program cosponsored by Wisconsin Psychiatric Association for 2 hours Category I credit of AMA-PRA.
—Physicians are encouraged to bring house staff and/or medical students as guests. Dinner tickets available from Kathryn Bemmann, MD, 251 West Broadway, Waukesha, Wis 53186; phone 414/542-4555.
—Students $7.50. Others $18.00 (part of this fee will cover student costs).

PSYCHIATRY FOR FAMILY PHYSICIANS

Thursday, March 27, 6:00-9:00 pm
Friday, March 28, 8:30 am-12:00 noon
Friday, March 28, 1:30 pm-4:00 pm

—A brief review course of psychiatry for the family physician. Three sessions of 3 hours each. Attendance limited to 35 physicians.
—Program is accredited through the Wisconsin Psychiatric Association for 9 hours Category I credit of AMA-PRA. Acceptable for 9 hours elective credit hours of AAFP.
—Program coordinators: Benjamin H Glover, MD, Madison; and Kathryn Bemmann, MD, Waukesha.
—No registration fee. However, advance registration is required.

IMPAIRED PHYSICIAN

Friday, March 28, 9:00 am-10:30 am

Featuring **SPECIAL PROBLEMS OF EMOTIONALLY ILL AND EARLY SENILE PHYSICIANS: RECOGNITION, TREATMENT, AND REHABILITATION**

—Introduction: *Gerald C Kempthorne, MD,* Spring Green
—Moderator: *Harry F Weisberg, MD,* Milwaukee
—Emotionally troubled physicians—patients with special needs, by *Herbert C Modlin, MD,* Topeka, Kan
—Early senility in physicians—recognition and treatment options, by *Albert A Fisk, MD,* Milwaukee
—Discussion

THYROID NODULES

Saturday, March 29, 9:00-10:20 am

—**Participants:** *Robert H Caplan, MD,* LaCrosse· *Edward N Ehrlich, MD,* Madison; *Eberhard A Mack MD,* Madison; and *Philip O Ruetz, MD,* Milwaukee
Panel is accredited through the State Medical Society of Wisconsin for 1.5 hours Category 1 credit of PRA-AMA and acceptable for 1.5 hours of prescribed credit by AAFP

Special programs/panels

NEUROLOGY

Friday, March 28, 1:45-3:30 pm

—Moderator: *Allan B Levin, MD,* Madison
—Panel is accredited through the SMSW for 3 hours Category I credit of AMA-PRA, and acceptable for 3 prescribed hours by the AAFP
—Newer diagnostic methods in the evaluation of surgical approaches to TIAs and related cerebrovascular disease: role of carotid endarterectomy and extracranial-intracranial bypass, by *Theodore S Roberts, MD,* Salt Lake City, Utah.
—Pathogenesis and management by TIAs and related cerebrovascular disease, by *Varum Soxena, MD,* Milwaukee
—Newer diagnostic methods in the evaluation of cerebral blood flow, by *Allan B Levin, MD,* Madison
—Discussion

AREAWIDE MCE STUDIES: CURRENT STATUS OF ACUTE APPENDICITIS CARE

Friday, March 28, 9:00 am-10:30 am

—Presented by Wisconsin Professional Review Organization, Inc.
—Program, cosponsored by SMS, is acceptable for 1.5 hours Category I credit of AMA-PRA.
—Physicians analyzing data collected from WisPRO's appendectomy Medical Care Evaluation study have concluded that care for acute appendicitis is generally of good quality. Patient lengths of stay and complication rates are both quite acceptable. This session will present an overview of the study's results, and discuss the following issues: [1] Patient education programs might decrease the number of people seeking care who have a perforated appendix. [2] Hospitals could obtain a lower percentage of patients who have a negative appendix, confirmed by pathology.

MEDICINE & RELIGION

Friday, March 28, starting at 7:15 am

—Breakfast, Catholic Physicians Guild.
—Speaker: *John O Simenstad, MD,* Osceola; Chairman, SMS Committee on Medicine & Religion; Chairman, SMS Cost Containment Committee
—Topic: A forgotten solution to health care costs

CHILD ABUSE

Friday, March 28, 9:00-10:20 am

—Recognition and management of child abuse, by *Robert W ten Bensel, MD,* Minneapolis, Minn
—Child protective service team—a model for management in semi-rural Wisconsin, by *Thomas N Roberts, MD,* LaCrosse
Program is accredited through SMSW for 1.5 hours Category I credit of PRA-AMA, and acceptable for 1.5 prescribed hours by the AAFP

PERINATOLOGY

Friday, March 28, 10:40 am-12:00 noon

—Review of the principles of perinatal care and its implementation in Wisconsin as well as the current concepts of management of high-risk obstetric patients and the many advances in newborn intensive care and followup of the infant.
—Moderator: *Perry A Henderson, MD,* Madison
—Perinatal care systems, by *Perry A Henderson, MD,* Madison
—Perinatal care in Wisconsin, by *Mr Daniel Bier,* Madison
—Perinatal services in Milwaukee, by *Phillip R Hamilton, MD,* Madison
—Perinatal services in Marshfield, by *James C Opitz, MD,* Marshfield
—Discussion

Panel is accredited through the SMSW for 1.5 hours Category I credit of PRA-AMA, and acceptable for 1.5 prescribed hours by the AAFP

PHYSICIANS AND THE SQUEEZE OF GOVERNMENT REGULATION

Friday, March 28, 9:00 am-10:30 am

—Moderator: *Marvin Parker, MD,* Racine
—Panel members will discuss the impact of the Certificate-of-Need program in Wisconsin and the recent developments on new State regulations for the implementation of the Decertification program for specialized hospital services. Other recent regulatory initiatives will be discussed. Panel members will include physicians who have experience with Certificate-of-Need and Decertification, State Division of Health staff, and SMS staff.

PRESIDENTS' RECEPTION AND DINNER

Friday, March 28, 6:30 pm—R/7:30 pm—D

—Guest: Governor Lee Dreyfus

Specialty Section programs—

ALLERGY & CLINICAL IMMUNOLOGY

Saturday, March 29, 12:15-4:00 pm

Moderator: *Robert Kriz, MD,* Madison

—Luncheon: Urticaria angioedema—clinical manifestations, pathogenesis and therapeutic approaches, by *Nicholas A Soter, MD,* Boston, Mass

—Cutaneous necrotizing venulitis, by *Nicholas A Soter, MD,* Boston, Mass

—Pharmacologic control of the airways, by *Donald Clayton, MD,* Madison

—Aspergillosis, by *John E Basich, MD,* Milwaukee

—Business meeting: Wisconsin Allergy Society

Program is accredited through the Wisconsin Allergy Society for 2 hours of Category I credit of the PRA-AMA

ANESTHESIOLOGY

Saturday, March 29, 10:30 am

—Board meeting: SMS Section on Anesthesiology

Saturday, March 29, 12:15-4:30 pm

Moderator: *Bonnie M Tompkins, MD,* Madison

—Luncheon

—Business meeting: SMS Section on Anesthesiology

—Myocardial oxygen consumption and coronary blood flow, by *Brian H Hoff, MD,* San Antonio, Tex

—Business meeting: SMS Section on Anesthesiology

—Considerations in myocardial infarction and cardiogenic shock, by *Brian H Hoff, MD,* San Antonio, Tex

—Current status of obstetrical anesthesia, by *Susan K Palmer, MD,* Milwaukee

Program accredited through AMA for 3 hours Category 1 credit of PRA; approved for 3 hours prescribed credit of AAFP

DERMATOLOGY

Saturday, March 29, 12:15-5:00 pm

Moderator: *Robert E Jordon, MD,* Milwaukee

—Luncheon

—Clinical presentations of melanoma, by *Lawrence Solomon, MD,* Chicago, Ill

—Lesions confused clinically with melanoma, by *Lawrence Bushkell, MD,* Milwaukee

—Histology, staging of melanoma, by *Lawrence Clowry, MD,* Milwaukee

—Melanoma in children, by *Lawrence Solomon, MD,* Chicago, Ill

—Immunology of melanoma, by *Robert E Jordon, MD,* Milwaukee

—Therapy of melanoma, by *Joseph Skibba, MD,* Milwaukee

—Panel discussion

Program accredited through Wisconsin Dermatological Society for 3.5 hours Category 1 credit of the PRA-AMA and acceptable for 3.5 hours elective credit of AAFP

EMERGENCY MEDICINE

Saturday, March 29, 12:15-3:30 pm

Moderator: *Gordon L Johnson, MD,* LaCrosse

—Luncheon

—Occupational pulmonary medicine, by *Edward P Horvath, MD,* Marshfield

—Business meeting: Wisconsin Chapter of the American College of Emergency Physicians

Program cosponsored by American College of Emergency Physicians; approved for 1.5 hours Category I credit; qualifies for 1.5 hours Category I credit of PRA-AMA; and acceptable for 1.5 hours elective credit of AAFP

FAMILY PRACTICE

Thursday, March 27, starting at 8:00 am

—Breakfast and Board meeting: Wisconsin Academy of Family Physicians

—See also information re Panel on PSYCHIATRY FOR FAMILY PHYSICIANS in *Special programs panels* section

INTERNAL MEDICINE

Saturday, March 29, 12:15-4:30 pm

Moderator: *Edwin L Overholt, MD,* LaCrosse

—Luncheon: Introductory remarks by *Joseph J Mazza, MD,* Marshfield; comments on American College of Physicians by its Wisconsin Governor, *Charles L Junkerman, MD,* Milwaukee

—Featuring UPDATE ON INFECTIOUS HEPATITIS

—The epidemiology of infectious hepatitis, by *John P Kirchner, MD,* Marshfield

—Immunotherapy for infectious hepatitis (Elvehjem Memorial Lecture), by *Leonard B Seeff, MD,* Washington, DC

—Panel: Doctors Seeff, Kirchner, Varma

Program, which has been approved for 3.5 hours of Category I credit by the American College of Physicians, is being cosponsored by the State Medical Society of Wisconsin

Specialty Section programs—

NEUROLOGY

Friday, March 28, 12:15-4:45 pm

Moderator: *Robert T Schmidt Jr, MD,* Green Bay

Featuring **ALCOHOLISM**

—Luncheon: An overview on the effects of alcohol on the nervous system, by *Maurice Victor, MD,* Cleveland, Ohio

—Mechanism and management of the alcohol withdrawal syndrome, by *Maurice Victor, MD,* Cleveland, Ohio

—Reactor panel, by *David Nelson, MD,* Stoughton; *Robert T Schmidt Jr, MD,* Green Bay; and *Joseph Benforado, MD,* Madison

—Nutritional aspects of alcoholism, by *Maurice Victor, MD,* Cleveland, Ohio

—Business meeting: Wisconsin Neurological Society (3:35 - 4:45 pm)

Program accredited through Wisconsin Neurological Society for 2.5 hours Category 1 credit of PRA-AMA; and acceptable for 2.5 hours prescribed credit of AAFP

OPHTHALMOLOGY

Friday, March 28

—Board meeting: SMS Section on Ophthalmology (9:00 am-12:00 noon)

—Panel on AREA WIDE MCE STUDIES: CURRENT STATUS OF ACUTE APPENDICITIS CARE (9:00 am-10:30 am) (see details under *Panels* section)

—SMS socioeconomic luncheon (12:15-1:15 pm)

—No afternoon scientific program

—Business meeting: SMS Section on Ophthalmology (2:00-4:00 pm)

—Evening dinner and scientific program starting at 5:30 pm, University Club, for SMS Section on Ophthalmology and Milwaukee Ophthalmological Society

ORTHOPAEDICS

Saturday, March 29, 9:00 am-4:30 pm

Moderator: *Paul K Odland, MD,* Janesville

—The effect of pregnancy on idiopathic scoliosis, by *David Mellencamp, MD,* Milwaukee, and Walter P Blount, MD, Milwaukee

—The pattern of venous drainage of the digits, by *George Lucas, MD,* Madison

—Pollicization by digital transposition, by *Clarence Klasinski, MD,* Stevens Point

—Topic to be announced, by *Harold E Kleinert, MD,* Louisville, Ky

—Luncheon

—Decision making in carpal navicular fractures, by *William Engber, MD,* Madison

—Ten-year followup and conclusions on navicular bone grafts, by *N G Papadakes, MD,* Janesville

—Conservative treatment of fingertip amputations, by *Barry Bast, MD,* Manitowoc

—Cast brace treatment of forearm fractures in adults, by *Harvey L Barash, MD,* Madison

—Results of electromagnetic field stimulation in the treatment of nonunion and delayed union of bone, by *Paul A Jacobs, MD,* Milwaukee

—Current surgical management of musculoskeletal malignancies, by *Thomas A Lange, MD,* Oregon

—Arthroscopic meniscectomy, by *John M Kirsch, MD,* Stevens Point

—Business meeting: Wisconsin Orthopaedic Society

Program is accredited through the Wisconsin Orthopaedic Society for 5 hours Category I credit of PRA-AMA

OTOLARYNGOLOGY

Saturday, March 29, 8:30 am-3:30 pm

Moderator: *Larry R Severeid, MD,* LaCrosse

—Closure of surgically created oral defects—overview, by *Charles Cummings, MD,* Seattle, Wash

—Major head and neck surgery for benign vascular lesions, by *Anthony B Krausen, MD,* Milwaukee, and *Robert H Ciralsky, MD,* Milwaukee

—The neuromuscular transposition flap: effectiveness in restoring function of denervated muscle, by *Charles Cummings, MD,* Seattle, Wash

—Interesting case presentations, by members of Wisconsin Otolaryngological Society

—Luncheon

—Business meeting: Wisconsin Otolaryngological Society

—Transoral approach to posterior pharyngeal wall and cervical spine, by *James A Duncavage, MD,* Milwaukee, and *Robert J Toohill, MD,* Wauwatosa

—Treatment of carcinoma of the tongue—reappraisal, by *Charles Cummings, MD,* Seattle, Wash

—Preservation of the 11th cranial nerve in radial neck dissection, by *Carlton Lee, MD,* Madison, and *James H Brandenburg, MD,* Madison

Program accredited through Wisconsin Otolaryngological Society for 5 hours Category 1 credit of PRA-AMA

ELVEHJEM MEMORIAL LECTURE

Immunotherapy for infectious hepatitis

Leonard B Seeff, MD, Washington, DC
Head, Section of Gastroenterology, Veterans Administration Hospital

INTERNAL MEDICINE Program
Saturday, March 29, 2:45 pm, MECCA

Specialty Section programs—

PATHOLOGY

Saturday, March 29, 9:30 am-5:00 pm

Moderator: *Richard Komorowski, MD,* Milwaukee

—Renal biopsy interpretation, by *John C Garancis, MD,* Milwaukee

—New developments in genitourinary pathology, by *F K Mostofi, MD,* Washington, DC

—Luncheon

—Business meeting: Wisconsin Society of Pathologists

—Seminar: Genitourinary pathology. Moderator: *F K Mostofi, MD,* Washington, DC

Program accredited through Wisconsin Society of Pathologists for 5 hours of Category 1 credit of PRA-AMA

PHYSICAL MEDICINE & REHABILITATION

Saturday, March 29, 12:15-5:00 pm

Featuring **CURRENT CONCEPTS**

Moderator: *Sridhar V Vasudevan, MD,* Milwaukee

—Modalities in physical medicine—especially diathermy—rationale and clinical indications, by *Richard F Harvey, MD,* Madison

—New modalities in management of chronic pain, by *Tai J Park, MD,* LaCrosse

—Somatosensory evoked potentials—a diagnostic and prognostic tool, by *William J LaJoie, MD,* Milwaukee

—Panel discussion

Program accredited by Medical College of Wisconsin for 3 credit hours in Category 1 of PRA-AMA

BEAUMONT MEMORIAL LECTURE

George E Block, MD, Chicago, Illinois
Professor of Surgery, University of Chicago Medical Center

SURGERY Program
Saturday, March 29, 4:10 pm, MECCA

SOCIO-ECONOMIC/WISPAC Luncheon

with **IRVING R LEVINE** speaking on
Politics '80 and Our Nation's Economy

Mr Levine's commentaries and reports have been regular features on "NBC Nightly News," "Today," and NBC News programs, and he is a frequent panel member on "Meet the Press."

Friday, March 28, 12:15 pm, MECCA

PLASTIC SURGERY

Friday, March 28, 12:15-4:30 pm

Featuring **UPDATE ON FLAPS**

Moderator: *Sidney K Wynn, MD,* Milwaukee

—Luncheon: Plastic surgical experiences, by *Phillip G Arnold, MD,* Rochester, Minn

—Myocutaneous flaps and others, by *Phillip G Arnold, MD,* Rochester, Minn

—Panel on flaps—which is best—where?, by *David G Dibbell, MD,* Madison; *Ruedi P Gingrass, MD,* Milwaukee; and *Glen M Tucker, MD,* Milwaukee

—Informal discussion by members of Wisconsin Society of Plastic Surgeons

—Argon Laser: Treatment of cutaneous vascular lesions and tattoos, by *Sidney K Wynn, MD,* Milwaukee

Program accredited through Wisconsin Society of Plastic Surgeons for 3 hours of Category 1 credit of PRA-AMA

—Annual business meeting: Wisconsin Society of Plastic Surgeons (3:45-4:30 pm)

—Social hour/dinner: Wisconsin Society of Plastic Surgeons (and guests), University Club (starting at 6:45 pm)

PSYCHIATRY

Friday, March 28, 9:00 am-12:10 pm

Featuring **THE FAMILY AND GENDER ISSUES: DO WOMEN/GIRLS AND MEN/BOYS GET QUALITATIVELY DIFFERENT MEDICAL CARE?**

Moderator: *Kathryn C Bemmann, MD,* Waukesha

—Introduction, by *Kathryn C Bemmann, MD,* Waukesha

—Womens' issues in medical care, by *Alexandra Symonds, MD,* New York

—Discussion

—Men and boys: some thoughts on their medical treatment and the male medical model, by *Thomas L Holbrook, MD,* Hartland

—Discussion

—The family as patient, by *David V Keith, MD,* Madison

—Discussion

—Summation

Program accredited through Wisconsin Psychiatric Association for 3 hours Category 1 credit of PRA-AMA, and acceptable for 3 hours prescribed credit of AAFP

Specialty Section programs—

RADIATION ONCOLOGY

Friday, March 28, 10:30 am

—Business meeting: Wisconsin Society of Radiation Oncologists

Friday, March 28, 12:15-4:30 pm

Moderator: *Thomas E Davis, MD,* Madison

—Luncheon: Small cell carcinoma of the lung—current data bearing on management, by *James D Cox, MD,* Milwaukee

—Featuring LYMPHOMAS—THE PERPLEXING DISEASE

—Lymphomas—Can we make any sense out of the histological pattern?, by *James J Butler, MD,* Houston, Tex

—Discussion

—The role of radiation therapy in lymphoma management, by *James C Cox, MD,* Milwaukee

—Discussion

—Chemotherapy—When to treat, and when not to, by *Tom Anderson, MD,* Milwaukee

—Discussion

—Panel: Doctors Anderson, Butler, and Cox

Program is accredited through the Wisconsin Society of Radiation Oncologists for 4.5 hours Category I credit of PRA-AMA

RADIOLOGY

Saturday, March 29, 9:00 am-12:00 noon

Moderator: *Thomas J Imray, MD,* Milwaukee

—Radiology of the biliary tract, by *John R Amberg, MD,* San Diego, Calif

—Discussion

—Air-contrast studies of the gastrointestinal tract—are they over-rated?, by *John R Amberg, MD,* San Diego, Calif

—Discussion

—Business meeting: Wisconsin Radiological Society

Program accredited by Medical College of Wisconsin for 2 credit hours in Category I of PRA-AMA; acceptable for 2 hours of prescribed credit in Category I by AAFP

RESIDENT PHYSICIANS SECTION

Friday, March 28, 9:00 am-4:00 pm

—Welcome and Chairman's report, by *Diana Kruse, MD,* Madison

—Vice-chairman's report, by *Ken Jensen, MD,* Milwaukee

—Report of SMS Delegates; discussion of resolutions

—AMA Delegates report

—Discussion of local housestaff affairs

—Nominations; election speeches; voting

—Adjournment for luncheon (optional: socioeconomic/WISPAC luncheon)

—The 'Doc' program—doctors oughta care, by *Alan Blum, MD*

—Panel discussion: 'Doc' in Wisconsin

SURGERY

Saturday, March 29, 8:00 am-5:00 pm

—Cholecystectomy in the aged patient at Columbia Hospital, by *Robert J Goldberger, MD,* Milwaukee

—The management of hiatus hernia, by *Robert E Condon, MD,* Milwaukee

—Ileus of the colon—review of some postoperative experiences, by *Donald P Davis, MD,* Milwaukee

—Chronic idiopathic intestinal pseudo-obstruction (case report), by *George F Flynn, MD,* Milwaukee

—Pseudo-aneurysms after vascular reconstruction, by *Lyle G Henry, MD,* Milwaukee

—A ten-year retrospective study of breast cancer treated surgically at Columbia Hospital, by *Gale Mendeloff, MD,* Milwaukee

—Occult lymphnode metastases and breast carcinoma, by *David Rothwell, MD,* Milwaukee

—Presidential address by *Charles E Yale, MD,* Madison

—Business meeting and luncheon: Wisconsin Surgical Society

Moderator: *Charles E Yale, MD,* Milwaukee, President, Wisconsin Surgical Society

—Presentations by Society members

—Panel discussion: The management of carotid and coronary artery disease in general surgical patients

—Discussion

—William Beaumont Lecture (topic to be announced) by Ward Griffen, MD, Lexington, Ky

Program is accredited through Wisconsin Surgical Society for 6 hours Category I of the PRA-AMA

—Evening dinner: Wisconsin Surgical Society (by invitation only), University Club

OUT-OF-STATE GUEST SPEAKERS

JOHN R AMBERG, MD: Professor of Radiology, University of California San Diego; Staff Radiology, Veterans Administration Medical Center, San Diego, California. *(Radiology* Program, Saturday, March 29, 9:00 am, MECCA)

PHILLIP G ARNOLD, MD: Department of Plastic Surgery, Mayo Clinic, Rochester, Minnesota. *(Plastic Surgery* Luncheon, Friday, March 28, 12:15 and 1:15 pm, MECCA)

ROBERT W TEN BENSEL, MD: Professor and Director, Program in Maternal and Child Health, University of Minnesota, Minneapolis. *(Child Abuse* Panel, Friday, March 28, 9:00 am, MECCA)

GEORGE E BLOCK, MD: Professor of Surgery, University of Chicago Medical Center, Chicago, Illinois. *(Surgery* Program, Saturday, March 29, 4:10 pm, MECCA)

KEVIN BUCKLEY: Program Manager, Division of Education and Publications, Joint Commission on Accreditation of Hospitals. *(Hospital Accreditation* Panel, Thursday, March 27, 12:00 noon, MECCA)

JAMES J BUTLER, MD: Professor and Pathologist, Department of Pathology, MD Anderson Hospital and Tumor Institute, Houston, Texas. *(Radiation Oncology* Program, Friday, March 28, 1:30 pm, MECCA)

CHARLES CUMMINGS, MD: Professor and Chairman, Department of Otolaryngology, University of Washington, Seattle, Washington. *(Otolaryngology* Program, Saturday, March 29, 9:00 and 10:20 am and 2:10 pm, MARC PLAZA)

F DIMOND, MD: Faculty, Joint Commission on Accreditation of Hospitals *(Hospital Accreditation* Panel, Thursday, March 27, 12:00 noon, MECCA)

D DUNCAN, MD: Faculty, Joint Commission on Accreditation of Hospitals *(Hospital Accreditation* Panel, Thursday, March 27, 12:00 noon, MECCA)

BRIAN H HOFF, MD: Associate Professor of Anesthesiology, Clinical Science Center, University of Texas, San Antonio, Texas. *(Anesthesiology* Program, Saturday, March 29, 1:00 pm and 3:00 pm, MECCA)

HAROLD E KLEINERT, MD: Louisville, Kentucky. *Orthopaedic* Program, Saturday, March 29, 10:45 am, MECCA)

HERBERT C MODLIN, MD: Professor of Community and Forensic Psychiatry, Menninger Foundation, Topeka, Kansas. *(Impaired Physician* Panel, Friday, March 28, 9:00 am; MECCA)

F K MOSTOFI, MD: Chief, Genitourinary Pathology Section, Armed Forces Institute of Pathology, Washington, DC *(Pathology* Program, Saturday, March 29, 11:00 am and 2:00 pm, MECCA)

THEODORE S ROBERTS, MD: Professor and Chairman, Division of Neurological Surgery, University of Utah Medical Center, Salt Lake City, Utah. *(Neurology* Panel, Friday, March 28, 1:45 pm, MECCA)

LEONARD B SEEFF, MD: Head, Section of Gastroenterology, Veterans Administration Hospital, Washington, DC *(Internal Medicine* Program, Saturday, March 29, 2:45 pm, MECCA)

LAWRENCE SOLOMON, MD: Professor and Head, Department of Dermatology, University of Illinois Medical Center, Chicago, Illinois. *Dermatology* Program, Saturday, March 29, 1:00 pm and 3:00 pm, MECCA)

ALEXANDRA SYMONDS, MD: Faculty, American Institute of Psychoanalysis-Karen Horney Center; Associate Clinical Professor of Psychiatry, New York University School of Medicine, New York. *(Women in Medicine* Panel, Thursday, March 27, 7:30 pm, MARC PLAZA; and Psychiatry Program, Friday, March 28, 9:10 am, MECCA)

NICHOLAS A SOTER, MD: Department of Dermatology, Harvard Medical School, Boston, Massachusetts. *Allergy and Clinical Immunology* Luncheon, Saturday, March 29, 12:15 pm; and Program, 1:30 pm, MECCA)

MAURICE VICTOR, MD: Professor of Neurology, Case Western Reserve University, Cleveland, Ohio. *(Neurology* Luncheon, Friday, March 28, 12:15 pm: and Program, 1:30 pm, MECCA) ■

SCIENTIFIC PROGRAM PLANNERS

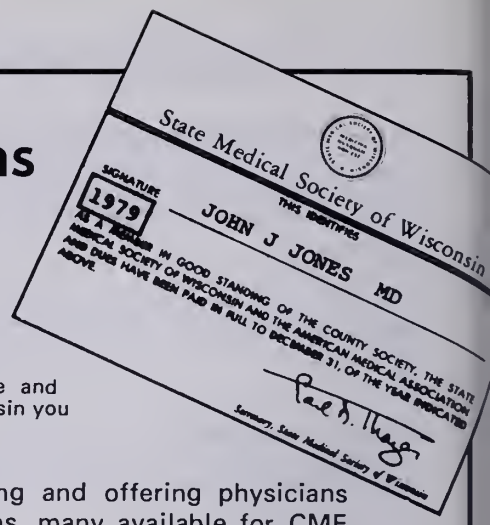
Commission on Continuing Medical Education

George A Bergland, MD,
Chairman, Milwaukee
Leonard H Wurman, MD,
Vice-chairman, Wausau
Joseph C Darin, MD, Milwaukee
Martin Z Fruchtman, MD, Waukesha
Bradley G Garber, MD, Osseo
Paul McAvoy, MD, Neenah
Edwin L Overholt, MD, LaCrosse
James T Houlihan, MD, Woodruff
John L Raschbacher, MD, Waukesha
Sigurd E Sivertson, MD, Madison
University of Wisconsin-Madison
Willard Duff, PhD, Milwaukee
Medical College of Wisconsin
Elizabeth A Steffen, MD, Racine
Council Liaison to Commission

Scientific Program Committee: Edwin L Overholt, MD, LaCrosse, *Chairman;* Paul McAvoy, MD, Neenah, *Cochairman.* Chairman, Scientific Exhibits: James T Houlihan, MD, Woodruff.

Staff: William G Wendle, *Scientific Affairs Coordinator;* Arlene K Meyer, *Administrative Assistant,* Continuing Medical Education.

Why 4,788 physicians carry this card!.....



These are challenging times for any profession —times when you need the active, aggressive support of your national, state, and county medical societies to give you the professional edge you need to advance and grow. As a member of the State Medical Society of Wisconsin you receive many valuable benefits. Among them:

- **SMS Annual Meeting**—Sponsored each spring and offering physicians quality scientific and socio-economic programs, many available for CME credit.
- **Wisconsin Medical Journal and Medigram**—These publications bring you the latest in medical news affecting you and your patients.
- **Wisconsin Physicians Planning Network**—Is working to assure physician representation in the health planning process and new health services systems.
- **An Organized Lobbying Effort**—Working in Madison to ensure Wisconsin physicians have a voice in healthcare problems and issues presented to the Wisconsin Legislature.
- **Medical Assistance Agreement and Super-Rule**—The SMS Physicians Alliance is closely monitoring and negotiating the formulation of the Medical Assistance Provider Agreement and Super-Rule now mandated by state law.
- **Mediation and Peer Review**—Physicians, through a special commission, are "policing the profession" by mediating complaints of the public against physicians and where necessary imposing discipline.
- **Impaired Physician Program**—Was recently formed to help the impaired physician—the doctor suffering in some degree from alcoholism, other drug dependency, or mental illness.
- **Member Benefit Plans**—The Society offers comprehensive life, health, and liability insurance plans for physicians and their families at attractive group rates. In addition, physicians can receive practice management tips at seminars sponsored by the Society and take advantage of car rental and travel programs at special low, "member" rates.
- **Grassroots Political Action**—Developed through the SMS Physicians Alliance, local physicians meet with their legislative representatives on a regular basis to discuss issues of importance to medicine.
- **Community Health**—Society physicians are working with community organizations and individuals in providing consumer health education programs to promote a healthier Wisconsin citizenry.
- **CESF**—The Society's Charitable, Educational and Scientific Foundation, through its physician members, administers a student loan program to help students prepare for careers in healthcare; sponsors postgraduate teaching programs for physicians; and for the past two years, has participated in a Jail Health Care Accreditation Program of the American Medical Association.
- **Uniform Claim Form**—These forms, developed by the Society working with local insurance carriers, can be used by physicians in submitting claims to all private insurance companies in Wisconsin, Medicare, and Medicaid.

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Rudolph C Hecht, MD,* Madison, Department of Family Medicine and Practice and Honorary Consul of Mexico in Madison, recently participated as a guest speaker at the First World Congress on Environmental Health in Development Planning held in Mexico City.

Michael Chojnacki, MD,* Oconomowoc, has left the Milwaukee Psychiatric Hospital where he has been associated for the past two years to do psychopharmacological research at the Texas Research Institute of Mental Sciences in Houston. Doctor Chojnacki is a graduate of the University of Chicago Pritzker School of Medicine and did his psychiatry residency at Columbia Presbyterian Medical Center in New York.

John Allen, MD,* Medical Director of the Wausau Medical Center and head of the Section on Occupational Medicine, recently was appointed to the Committee on Occupational Medicine of the American Group Practice Association.

George T Anast, MD, Woodruff, recently was elected to fellowship in the American Association for the Surgery of Trauma. Doctor Anast is a charter member of the American College of Emergency Physicians and a fellow of the American College of Surgeons. He also is medical director of Wisconsin's Emergency Medical Services (EMS) systems Development Section.

Gus Stelzer, MD and **Rod Olson, MD,** Eau Claire, have agreed to start a new physicians group in Rice Lake in June. Both currently are completing residency training through the Eau Claire Family Practice Residency Program. Doctors Stelzer and Olson graduated from the University of Minnesota Medical School in 1976.

Jerome A Heubner, MD, Platteville, recently became associated with the Doctors Park Family Physicians. A diplomate of the American Board of Family Practice, Doctor Heubner graduated from the University of Wisconsin Medical School, Madison, and recently completed his residency program with the Department of Family Medicine and Practice at the University.

Kenneth L Ubben, MD, Rhinelander, has joined the W S Bump Medical Group, SC in the department of dermatology. A graduate from the University of Iowa Medical School, Doctor Ubben completed a rotating internship at La Crosse Lutheran Hospital and then became a flight surgeon in the U S Air Force serving for two years at Minot AFB, North Dakota. Following his military service, he practiced general medicine with Group Health Plan, Inc, in Minneapolis-St Paul. His residency in dermatology was completed at the University of Minnesota Medical School.

William J Carlson, MD, has joined the medical staff of the Cantwell-Peterson Clinic in Shawano. Doctor Carlson graduated from the University of Wisconsin Medical School, Madison, in 1976 and did his residency in Family Practice at St Paul.

James A Hamp, MD,* Ashland, recently was appointed to the medical staff at the Memorial Medical Center. An otolaryngologist, Doctor Hamp graduated from the University of Michigan Medical School, Ann Arbor, and completed his residency at the University of Oregon Health Science Center Hospital. He is associated with James O Shaw,MD.*

Jack C Westman, MD,* professor of psychiatry at the University of Wisconsin Medical Center, Madison, presided over the 31st annual meeting of the American Association of Psychiatric Services for Children (AAPSC), held at the Chicago Marriott Hotel, November 14-18, 1979. Doctor Westman was installed as president of AAPSC at last year's conference.

Gary L Shepherson, MD, Burlington, was erroneously reported to have completed an OB-GYN residency at Milwaukee County General Hospital (October 1979 issue, *Wisconsin Medical Journal). WMJ* has been informed that Doctor Shepherson completed only one year of a four-year program and then changed his career to the field of Family Practice. *WMJ* apologizes for this misinformation.

George T Bryan, MD* of the Wisconsin Clinical Cancer Center in Madison is a coauthor of a chapter entitled "Bracken Fern, a Natural Urinary Bladder and Intestinal Carcinogen" in *Naturally Occurring Carcinogens, Mutagens and Modulators of Carcinogenesis,* EC Miller *et al,* editors, Baltimore: University Park Press, 1979. He also helped prepare a chapter on "Etiology and Carcinogenesis: Natural Systems Approaches to Causality and Control" in *Principles and Management of Urologic Cancer,* N Javadpour, editor, Williams and Wilkins Press, 1979. Doctor Bryan also spent some time during 1979 in Turkey continuing his research on bracken fern.

WMJ's error. Our apologies to MDs Dennis Henzig and Timothy Bowers,* Wisconsin Rapids, for incorrectly stating their medical schools. Doctor Henzig graduated from the University of Wisconsin Medical School, Madison, and Doctor Bowers from the University of Iowa Medical School. ■

News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Milwaukee Psychiatric Hospital, Wauwatosa, has received a full two-year accreditation from the Joint Commission on Accreditation of Hospitals. The hospital has been continually accredited since November 1958. Gerald E Schley, president, said, "the accreditation signifies that the hospital meets or exceeds the 'optimal standards' established by the Joint Commission as they relate to patient care." Milwaukee Psychiatric Hospital, a nonprofit, nonsectarian facility, observed its 95th year in 1979.

The Wausau Medical Center recently was host to the Central Wisconsin Pediatric Society meeting at the Wausau Medical Center building. The meeting brought together pediatricians from Wausau, Marshfield, Stevens Point, and Rhinelander. The main speaker was Heinz Eichenwald, MD, Professor and Chairman of the Department of Pediatrics at the University of Texas Southwestern Medical School. His topic was entitled "Recent Advances in Antimicrobial Therapy in Children."

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SERVING SOUTHERN-CENTRAL WISCONSIN

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Rennebohm
Rexall DRUG STORES

Holy Family Hospital, Manitowoc, recently announced the election of officers to its medical staff. John A Thranow, MD,* was reelected president. Other MDs elected to serve on the executive committee are Robert D Bush, president-elect; David D Pfaffenbach,* secretary-treasurer; Walter F Smejkal,* past president and chief of surgery; Edward J Barylak* and David A Satchell, members-at-large; Lynn W Holder, chief of medicine; Paul L Karrmann,* chief of obstetrics and gynecology; Richard E Mansfield, chief of pathology; Michael A Jacobs,* chief of radiology; and Wayne F White,* chief of anesthesia.

Medical assistants from physician's offices throughout Wisconsin received tips on everything from effective job searching to improving memory skills at the Professional Development & Advancement Seminar sponsored by the Wisconsin Chapter of the American Association of Medical Assistants (AAMA) in November. The seminars have been held twice a year to aid medical assistants in their professional growth and to improve job skills. Physicians are encouraged to support these and other programs of the AAMA by seeing that their medical assistants attend.

St Nicholas Hospital, Sheboygan, recently announced the election of new officers of its medical staff. Burnell F Eckardt, MD*, was elected president to succeed Edward G Schott, MD* who had completed two successive terms as president. Other MDs elected are: Otto K Stewart,* vice-president and Arved O Ashby,* secretary-treasurer. Doctor Eckardt received his medical degree from the University of Wisconsin Medical School, Madison, in 1940, and has been in practice in Sheboygan since 1946. He also has served as president of the Sheboygan County Medical Society.

Froedtert Memorial Lutheran Hospital, Wauwatosa, has announced the results of the first election of officers to the hospital's medical staff. MDs elected are chief-of-staff, Russell K Lawson, chairman and professor of urology, Medical College of Wisconsin and vice-chief-of-staff, Ronald K Kalkhoff, professor of medicine and pharmacology, chief of the Medical College of Wisconsin's endocrine and metabolic section. According to Charles L Junkerman, MD,* vice-president for academic and professional affairs, the present interim medical staff of 27 is made up of 18 full-time Medical College of Wisconsin faculty members and 9 clinical faculty, physicians who are in private practice in the area and donate their time to the College's teaching programs. The 285-bed teaching tertiary care hospital will be opened in mid-year 1980. ■

WPS

report

for Wisconsin Physicians

/olume IX, Number 1

January, 1980

HEALTH INFORMATION BROCHURES

/PS currently has six health information brochures vailable for distribution which concern various spects of achieving healthier and happier lifestyles. ach is available to interested physicians, clinics, istitutions, organizations and community groups, nd each can be tailored to appropriate patient duction activities.

lcoholism is a 36 page booklet which describes arying degrees of alcohol dependence and the haracteristics of progressive alcoholism. The oblems of recovering from alcohol abuse and aintaining that recovery in a drinking world are scussed

onsider Your Health is a 6 page brochure designed r use by the general public as a guide to preventive ealth care The booklet provides information on ow to create a self-health situation which minimizes se of inappropriate and expensive medical facilities nd maximizes individual responsibility for preven- ve health maintenance.

rug Abuse: The Chemical Cop-Out is a 48 page ooklet which provides basic, easily understood, ndid information on dangerous drugs and arcotics It also looks at drug abusers and examines me of the factors which may contribute to in- eased abuse.

ow To Be A Wise Ol'Bird is a 13 page booklet signed to assist the senior citizen and retiree in tting up and maintaining a rewarding and healthy estyle after retirement. The brochure contains information on financial planning and health maintenance as well as general tips on enjoying one's newfound leisure time.

Sports Injuries - Prevention and Care, is a 20 page booklet designed to meet the needs of the growing numbers of people engaged in physical fitness activities. Developed with the cooperation of sports medicine specialists, the brochure describes sensible precautions which the amateur athlete can take to avoid the most common injuries associated with vigorous exercise. If such injuries occur, the booklet provides useful information for their treatment and care.

Suicide: The Will To Die is a 32 page booklet which attempts to show that suicide is a serious community health problem. It illustrates that almost anyone may attempt suicide given a critical set of personal frustrations, failures and depressions.

Up to 25 copies of the brochures can be obtained free from WPS. There will be a nominal charge of 20 cents per brochure for orders of more than 25. Simply request the title and quantity of the brochure desired and mail the request to Communications Division, WPS, P.O. Box 8190, Madison, WI 53708.

Smoking, a 4 page flyer on the health hazards associated with this activity, has recently been produced by WPS. This flyer is appropriate for distribution to patients within the medical institutional setting and may be ordered, free, by requesting "Smoking" from the above address.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

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and their Medical Assistants

WPS MAJOR MEDICAL COVERAGE

Undoubtedly your office has received the following statement on a WPS Provider Explanation of Benefits:

74--These charges should be submitted to WPS by the patient on a Major Medical Claim Form.

Since this statement is the most common denial of benefits on behalf of a WPS policyholder, a brief explanation of WPS Major Medical endorsements may be of assistance.

Many WPS group health insurance policies contain both basic and Major Medical coverage. Most basic coverage reimburses basic medical services such as surgery or inhospital medical treatment up to a dollar figure for any specific illness or condition. Major Medical coverage reimburses those services up to another dollar figure after basic coverage has been exhausted. In either case, basic coverage and Major Medical reimbursement is limited to usual, customary and reasonable charges. In addition, Major Medical coverage pays for doctor's office calls, some drugs, nursing care, medical supplies and services, and other services or medical items not generally payable under the basic coverage.

Two features of Major Medical coverage must be emphasized: deductible and co-insurance. A deductible is a fixed dollar amount for which the policyholder is responsible for covered health care costs before the insurance begins to pay the covered benefits of the remaining costs. For example, if the Major Medical deductible is $50.00 per calendar year (they vary), statements for $50.00 in covered charges for the patient during that calendar year must be submitted before WPS reimbursement can begin. Deductibles for family coverage usually apply to no more than three family members per calendar year.

Co-insurance is an arrangement by which the policyholder pays a specific, continuing portion of the cost of his or her medical care. For example, if the Major Medical co-insurance rate is twenty percent, WPS will pay eighty percent of covered charges after the deductible has been fulfilled up to the maximum amount payable for a specific illness or condition while the policyholder is responsible for twenty percent.

Claims for services covered under Major Medical endorsements must be submitted on a special Major Medical Claim Form along with the appropriate itemized bills. It is the policyholder's responsibility to complete and send the form to WPS, and WPS reimburses the policyholder directly. The policyholder may obtain Major Medical Claim Forms, with instructions for completing them, from:

WPS
Inquiry Services
P.O. Box 8190
Madison, WI 53708

or, in many cases, from his or her place of employment. Claims may be submitted by the policyholder whenever covered services occur or may be submitted at regular intervals.

A policyholder may discover the details of the specific Major Medical endorsement by reading his or her policy, contacting the fringe benefit officer at the place of employment, or by contacting WPS Inquiry Services at the above address or by telephone (608-221-4711).

WPS notifies both the physician's office and the policyholder by means of the code 74 statement whenever services are not covered under basic benefits but are covered under Major Medical. Therefore, when the policyholder secures itemized bills from the physician's office for the appropriate services named under the code 74 statement, a Major Medical Claim may be submitted, with WPS reimbursement to follow after the deductible has been fulfilled. The WPS Major Medical endorsements are designed, not only to provide coverage for catastrophic illness, but also through the deductible and co-insurance mechanism, to increase the patient's responsibility for health care spending and thereby encourage judicious health care expenditures.

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICFS, and MISCELLANEOUS. RATES: 30¢ per word, with a minimum charge of $12.00 per ad. BOXED AD RATES: $15.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781.

Physicians Exchange

WANTED: ONE OR TWO FAMILY physicians or internists. New fully equipped suite of offices available in 40-bed accredited hospital. Guaranteed income. College community, excellent school system, recreational activities. Economy based on several stable national industries. Write or phone Robert Housek, Administrator, Ripon Memorial Hospital, Ripon, Wis 54971. Tel: 414/748-3101. 12tfn/79

THE WAUSAU MEDICAL CENter, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Dermatology
- Otolaryngology
- Pediatrics

Beautiful new clinic building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Fringe benefits include retirement plan, medical and hospital insurance, and others. Excellent vacation and time-off plan. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. We would be pleased to hear from interested physicians. For more information, write John Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wis 54401; or call collect 715/847-3223. 8tfn/79

WANTED: GENERAL SURGEON, board certified or eligible to join seven-man family practice group in a university town with trade area population of 22,000, 30 miles southeast of St Paul, Minn. JCAH approved hospital. Contact Roland M Hammer, MD, River Falls Medical Clinic, Ltd, River Falls, Wis 54022, or call 715/425-6701. 12tfn/79

MULTISPECIALTY GROUP OF 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist
- Dermatologist
- Family Practitioner

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

FAMILY OR GENERAL PRACtitioner: One or two to serve community of Omro located ten miles west of Oshkosh on Highway 21. Modern, well-equipped facility available with option to buy or lease. Financial assistance available through community organization. Vacancy created by death of community physician. Hospital located 20 minutes away. 330 beds. Practice possibilities are unlimited due to growth of community and surrounding area. Please contact: Elaine Peck, RN, 223 Jackson Ave, PO Box O, Omro, Wis 54963. Tel: 414/685-2228. g5tfn/79

GROUP HEALTH COOPERATIVE of South Central Wisconsin. A growing federally qualified staff model HMO is recruiting internists, OB/GYN, and family practitioners for July 1980. Excellent salary, pension, and benefit program in an area of natural beauty making living and working here very attractive. Write or call David S Grab, MD, Medical Director, 1 South Park St, Madison, Wis. Phone 608/257-9700. An Equal Opportunity Employer. 1-3/80

FAMILY PRACTICE RESIDENcy—Second-year position available July 1980. Accredited program is community-based and affiliated with the University of Iowa College of Medicine. Generous stipend and fringe benefits. Contact: C A Waterbury, MD, Director, 441 East San Marnan Dr, Waterloo, Iowa 50702. Tel: 317/234-4419. 1/80

WANTED: PHYSICIAN TO JOIN group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Marie Olson, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

FAMILY PRACTITIONER TO join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

FAMILY PRACTICE PHYSIcians—Excellent practice opportunities in a thriving rural community. Enjoy life and your practice. We offer an income guarantee; other financial assistance; excellent facilities; a personal, friendly atmosphere and easy access to recreational and cultural activities. Join the active medical staff of a growing 112-bed JCAH accredited community hospital. Send curriculum vitae in confidence to: Frank Brady, Administrator, Fairbury Hospital, 519 South 5th St. Fairbury, IL 61739. pl/80

PHYSICIANS—NEED A CHANGE of lifestyle? or a new practice situation?? One of our hundreds of openings nationally is probably the one you are looking for! We confidentially match your geographical financial, and practice requirements to our many openings and give you detailed information on the practice situations that meet your requirements. There is no charge or obligation to you. Call Durham Medical Search, 717-A Statler Office Bldg, Buffalo, NY 14202. 716/852-5911. pl/80

Physicians Exchange

continued

WANTED: FAMILY PRACTICE physician to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

THE NICOLET CLINIC, SC A PROgressive 33-physician multispecialty group is looking for physicians in the following areas of practice:

- Pediatrics
- Nephrology
- Dermatology
- Family Practice

Modern, state of the art facilities, adjacent to Theda Clark Regional Medical Center and another building located on the Fox River. First-year salary open; full membership after one year. Liberal benefits including qualified Profit-Sharing Plan, and emphasis upon continued education. Outstanding professional and personal life-style opportunities. Excellent recreational area, located on the north end of Lake Winnebago. For more information, send letter and resume in confidence to E E Wilson, MD, Chairman, Recruiting Committee, or D J Anderson, FACMGA, Admin, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956, or call 414/725-7071.
12/79,1-5/80

OB-GYN WANTED — TO PRACtice in conjunction with a 4-member OB-GYN Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 471 in care of the Journal. 9tfn/79

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency
9tfn/79

FAMILY PHYSICIAN: APPLETON, Wi—to join 4 certified ABFP physicians. City of 60,000, economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact K E Buchanan, MD, 620 Longview Dr, Appleton, Wis 54911 or tel: 414/734-7144.
1-3/80

FAMILY PRACTITIONER WANTed. 13-man, mixed group practice seeking family practitioner to join its Family Practice Department of six family practitioners located 100 miles south of the Twin Cities in a community of 25,000. Ideal community with excellent schools and multiple recreational opportunities, new hospital. Liberal benefits and top salary offered. This is a choice practice opportunity in rural southern Minnesota. Please contact James Burns, MD, 210 N St Mary St, Albert Lee, Minn 56007. Tel: 507/373-1441. pl-4/80

ANESTHESIOLOGIST AVAILABLE for relocation. Mid-40s, Board certified, Wisconsin license. Will consider smaller cities. Write Dept 474 in care of the Journal. pl1-12,1/80

ORTHOPEDIC SURGEON—urologist—ENT—gynecologist needed for a primary-care group of ten physicians, one internist, one surgeon in northwestern Wisconsin. Contact L R Cotts, MD, 715/234-9031, 1020 Lakeshore Dr, Rice Lake, Wis 54868.
12/79,1-2/80

WANTED: DIAGNOSTIC RADIologist to join two-man service corporation covering 185-bed hospital and 32-physician clinic. Consideration for early partnership. Contact Jacob M Gerend, MD, 705 Oak Tree Rd, Sheboygan, Wis 53081. Tel: 414/458-0050.12/79,1-5/80

WANTED: GENERAL SURGEON to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935.
12tfn/79

RACINE MEDICAL CLINIC, SC, multispecialty group of 18 physicians has a practice association for

- Internist
- Obstetrician-Gynecologist
- Family/General Practitioner

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 7tfn/79

PSYCHIATRIST—MEDICAL DIrector for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

BOARD CERTIFIED OR ELIGIble primary care internists and family practitioners wanted for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel:414/289-5910.
1-6/80

FAMILY PRACTITIONER wanted for rural area in NW Wisconsin, town of 2500, service area includes 25,000 patients. Joint four ABFP and one Board certified surgeon in a growing family oriented group practice. Excellent salary and benefits. New large clinic building ready for occupancy June 1, 1980, close to JCAH approved hospital. The service area is one of the most desirable living areas in Wisconsin with unlimited outdoor recreation available. Contact: Paul G Goellner, MD, Spooner Clinic Ltd, Spooner, Wis 54801. Tel: 715/635-2151. 10-12/79, 1/80

FIFTY-MAN MULTISPECIALTY group has an immediate opening for:

- Orthopedic Surgeon
- Ophthalmologist
- Family Practice
- Psychiatrist

Excellent starting salaries with all fringe benefits. Monroe is a very stable economically-strong community of 10,000 located 45 minutes from Madison and 90 minutes from Milwaukee. If interested, please contact T E Peters, MD, The Monroe Clinic, Monroe, Wis 53566. 9-12/79, 1-2/80

WANTED: INTERNIST, BOARD certified or eligible to join (July 1, 1980) nine physician multispecialty group of four internists, two pediatricians, two OB-GYN, and general surgeon; clinic building next to community hospital expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Tel: 414/673-5745 (collect). 1tfn/80

OB-GYN SPECIALISTS DESIRED. Enjoy the security of group practice with the freedom of independent practice. If you are Board certified or Board eligible in OB-GYN, we have an interesting opportunity for you. One or two specialists are needed immediately to form an independent OB-GYN practice in a very desirable Northern Wisconsin community with a drawing population of 65,000. Active practice assured. All major specialists available for consultation. Business advice, technical and legal, will be provided. Outstanding personal benefit programs available. Income potential great. Generous starting income guaranteed. A 35 million dollar hospital just opened with available office space. For further information call 715/842-3202, or write Mr Lloyd Engstrom, PO Box 1646, Wausau, Wis 54401. 10tfn/79

NEUROLOGIST WANTED — Clinical Neurologist wanted to practice in conjunction with a 6-member Internal Medicine Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 470 in care of the Journal. 9tfn/79

NEUROLOGISTS: BOARD ELIgible or certified neurologists sought for practice with busy neurosurgical group. Prefer experience with EEG and EMG. Excellent starting salary and fringe benefits. Contact Dept 472 in care of the Journal. 11tfn/79

FAMILY PHYSICIAN OR General Practitioner. Excellent opportunity for the new physician desiring a good start or the experienced physician wanting a change. Progressive community located 30 miles east of Green Bay is seeking another physician to join the Algoma Clinic. Service area of over 6,000 presently served by four very active, cooperative, talented physicians. Good hospital (JCAH) approved in town. Generous starting income guaranteed with tremendous future and income potential. Full partnership after one year if desired. Rural living with small town privacy yet close to bigger cities of Green Bay and Milwaukee. Excellent recreational area for fishing, hunting, camping, boating, sailing, cross country and downhill skiing. Fine schools, library, churches, and social organizations. We would enjoy showing you and your family what we have to offer. For further details call collect or contact Steven H Spencer, Admin, Algoma Memorial Hospital, Algoma, Wis 54201. Tel: 414/487-5511. 12/79*

TWO FAMILY PRACTICE PHYSIcians to join or associate with multispecialty group in satellite setting in semi-rural community 30 miles north of Milwaukee in beautiful Kettle Moraine. Financial arrangements, benefits, and practice opportunity exceptional. Contact Executive Director, Hartford Memorial Hospital Foundation. Tel: 414/673-2300 (collect) 11-12/79,1/79

GONZALEZ MEDICAL CENTER is seeking a pediatrician who is fluent in Spanish to join an established and successful practice. Minimum income guaranteed. Contact R Gonzalez, MD, telephone 414/344-1120; 414/671-5410; 414/476-8624. 8-12/79, 1/80

GENERAL INTERNIST WITH GI endoscopic interest or gastroenterologist with interest in general internal medicine. To join busy internist with interest in rheumatology. Large consulting practice in Manitowoc-Two Rivers, Wis area. Call or write to discuss salary and other details. Info: J L Stoune, MD, Medical Arts Bldg, 600 York St, Manitowoc 54220. 5tfn79

PEDIATRICIAN TO JOIN 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Medical Facilities

SPACE AVAILABLE IN WESTwood professional building, Delafield, Wis. 2000 sq ft on ground level; design your own floor plan. Easy access to I-94. Oconomowoc Memorial is just 10 minutes away. Negotiable lease. Call 414/276-0431 or 414/646-2340. 11tfn/79

FAMILY PRACTICE AVAILABLE for one or two physicians. Thirty-year established practice of deceased physician. Excellent accredited hospital facilities located in Menomonee Falls, Wisconsin and only 10 miles from Milwaukee County Medical Complex. Area offers good schools and recreational facilities for family. Write to PO Box 307, Menomonee Falls, Wis 53051, or phone 414/251-5655. g12tfn/79

MEDICAL OFFICE SPACE available. Layton Medical Bldg, 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel: 414/258-5158. 5tfn/79

FOND DU LAC FACILITY. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

BEAUTIFUL MEDICAL BUILDing for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

MEDICAL SUITES AVAILABLE IN new medical building. Attached parking ramp. Adjacent to major hospital. For details call 414/637-5681, Racine, Wisconsin. 1tfn/80

GREEN BAY, WISCONSIN NEW prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

OFFICE SPACE AVAILABLE FOR general or unlimited practice in Elkhorn, Wis. Contact Dept 476 in care of the Journal. 1-3/80*

Recreational

FOR RENT: CARIBBEAN PARadise furnished two bedroom apartment near golf, private pool, beach, tennis, twenty minutes from St Thomas $300.00/week. Write: Joseph E Binard, MD, Naval Hospital, Roos Roads, Puerto Rico, FPO, Miami, Florida 34051. p12/79,1-2/80

Real Estate

DOCTOR OF FLORIDA REAL ESTate. A retired colleague of the Society will help you in the selection of a retirement home, condominium, investment property or tax shelter anywhere in Florida. Realty World, Holt Realty, Inc—Realtor: Howard V Morter, MD, Realtor-Associate; 336 Golfview Rd, North Palm Beach, Florida 33408 (residence address) 305/622-7006 home; 305/844-6574 office. pl/80

Bookshelf

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Current Surgical Diagnosis and Treatment. 4th Edition. By J Englebert Dunphy and Lawrence W Way. 1979. Lange Medical Publications, Drawer L, Los Altos, Calif. Pp 900. Price: $19.00.

Skin Deep. By Donald T Moynihan, MD and Shirley Hartman. Little Brown and Company, Boston, Mass. 1979. Pp 339. Price: $10.00.

The Truth About Senility—And How to Avoid It. By Lawrence Galton. Thomas Y Crowell Company, 10 E 53rd St, New York, NY 10022. 1979. Pp 244. Price: $9.95.

How To Improve Your Child's Behavior Through Diet. By Laura J Stevens and Rosemary B Stoner. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. Pp 346. Price: $9.95.

The Vitamin Book. By Rich Wentzler. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. Pp 224. Price: $4.95.

Winning The Losing Battle. By Eda Le Shan. Thomas Y Crowell Company, 10 E 53rd St, New York, NY 10022. Pp 182. Price: $8.95.

Cooking Creatively For Your Diabetic Child. By Caroline Hastings Babington. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 224. Price: $8.95.

Against Ourselves. By D G Garan. Philosophical Library, Inc, 15 East 40th St, New York, NY 10016. 1979. Pp 310. Price: $9.75.

The Last Taboo—Sex and the Fear of Death. By James L Brain. Doubleday and Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 256. Price: $8.95.

Borrowing Time: Growing Up With Juvenile Diabetes. By Pat Covelli. Thomas Y Crowell Company, 10 E 53rd St, New York, NY 10022. 1979. Pp 160. Price: $8.95.

Conference on Recertification, Sept 20, 1978. American Board of Medical Specialties, 1603 Orrington Ave, Evanston, Ill 60201. 1979. Pp 122.

Clear Skin. Kenneth L Flandermeyer, MD. Little, Brown and Co, Boston, Mass 02109. 1971. Pp 211. Price: $8.95.

Women Can Wait: The Pleasures of Motherhood After 30. By Terri Schultz. Publicity Department, Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 191. Price: $4.95.

Correlative Neuroanatomy & Functional Neurology. By Joseph G Chusid, MD. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1979. Pp 464. Price: $12.00.

Cry Babel. By April Oursler Armstrong. Publicity Department, Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 252. Price: $8.95.

The Courage to Live. By Ari Kiev, MD. Thomas Y Crowell, Publishers, 10 E 53 St, New York, NY 10022. 1979. Pp 148. Price: $7.95.

The Diagnosis & Treatment of Alcoholism. Edited by Jack H Mendelson, MD & Nancy K Mello, PhD. McGraw-Hill Book Co, 1221 Avenue of the Americas, New York, NY 10020. 1979. Pp 405. Price: $17.50.

Publications

Manual for Staging of Cancer 1978. Incorporates numerous anatomic sites and includes introductory chapters on the philosophy of the staging of cancer and the appropriate calculation of survival rates. In addition, two separate fascicles on "Staging System for Cancer at Gynecologic Sites" and "Reporting of Cancer Survival and End Results," which have been extracted from the Manual, also have been published. Copies of the Manual and/or the separate fascicles may be obtained at no charge by writing to the American Joint Committee (AJC), 55 East Erie Street, Chicago, Ill 60611. 1/80

Hematuria—A Warning Signal. This latest sound, color film in a series of patient-oriented audiovisual programs produced by Norwich-Eaton Pharmaceuticals is now available on a free-loan basis and for purchase. The 12-minute, 16-mm film was authored by John Coleman, MD, Cornell University Medical School, New York City. The film dramatizes the problems of three patients who, for various reasons, have found that they have blood in the urine. Using art, animation, and patient-physician sequences, the film demonstrates the causes of hematuria by showing the diagnostic methods available to physicians. Arrangements to borrow the film may be made by contacting: Film Library, Norwich-Eaton Pharmaceuticals, Norwich, New York 13815. 1/80

The new 1980 directory of medical films, audiovisuals, and medical education resources available from Norwich-Eaton Pharmaceuticals lists ten new 16-mm films and five 35-mm slide/audio cassette tape programs produced during the last year and now available on a free-loan basis. In all, the directory describes 223 films and slide programs, as well as medical service publications, the Norwich-Eaton Medical Science Teaching Series, and the Norwich-Eaton Professional Speakers Programs in nutrition, spasticity, and urology. Although the films and slide programs deal primarily with urologic subjects, other special interest areas include plastic and reconstructive surgery, burn therapy, gynecology, nutrition, dentistry, neurology, and spasticity (physician medicine and rehabilitation.) The ten new 16-mm, color, sound films all discuss genitourinary subjects. Write for information to; Norwich-Eaton Pharmaceuticals, Division of Morton-Norwich, Norwich, New York 13815. 1/80

Advertisers

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Valium®
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Upjohn Company, The 20,21,22
Motrin® ■

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 30¢ per word, with a minimum charge of $12.00 per listing. BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

1980 Wisconsin

Feb 12-14: Telemark Symposium and Ski Outing, Mt Telemark, Cable, Wis, sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians. Faculty from the Mayo Clinic. Six hours AAFP and AMA Category I credit. All physicians invited. Info: WAFP, 850 Elm Grove Rd, Elm Grove, Wis 53122.

Feb 18: *Great Lakes Ski-In: Survival in Emergency Medicine.* Playboy Club, Lake Geneva. Info: J Gennrich, MD, Wisconsin ACEP, 10201 W Lincoln Ave, Milwaukee 53227. Tel: 414/545-5568

Feb 21: *A Day of Cardiology.* Methodist Hospital, 309 W Washington Ave, Madison. Approved 4 hours prescribed credit AAFP and Category 1 PRA-AMA.

Mar 1-8: 15th Annual Clinical Conference, sponsored by the Medical College of Wisconsin and the Marquette-MCW Medical Alumni Association, Wailea Beach Hotel, Maui, Hawaii. Info: Marquette-MCW Medical Alumni Association, 8701 Watertown Plank Rd, Milwaukee, Wis 53226 (414/257-8204).

Mar 12: *A Day of Cancer, Prevention and Therapy.* UW Center for Health Sciences, 600 N Highland Ave, Madison. Approved 4½ hours prescribed credit AAFP and Category 1 PRA-AMA.

Mar 13-14: *An Update on Infectious Diseases for the Practicing Physician,* Clinical Science Center, Madison. Fee: $120. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

Mar 27-29: *4th Annual Ophthalmology Current Concepts Seminar '80,* The Concourse, Madison. Fee: $115. Info: Sarah Z Aslakson, CME, 465B WARF Bldg. 610 Walnut St, Madison, Wis 53706.

Mar 27-29: State Medical Society of Wisconsin Annual Meeting. MECCA and Marc Plaza, Milwaukee.

Mar 27: Wisconsin Academy of Family Physicians Board Meeting, Marc Plaza, Milwaukee.

Mar 28: Wisconsin Neurological Society Business Meeting, MECCA, Milwaukee.

Mar 28: State Medical Society Section on Ophthalmology Business Meeting, MECCA, Milwaukee; and Dinner, University Club.

Mar 28: Wisconsin Society of Plastic Surgeons Annual Business Meeting, MECCA, Milwaukee.

Mar 28: Wisconsin Society of Radiation Oncology Business Meeting, MECCA, Milwaukee.

Mar 29: Wisconsin Allergy Society Business Meeting, MECCA, Milwaukee.

Mar 29: State Medical Society Section and Business Meeting on Anesthesiology, MECCA, Milwaukee.

Mar 29: Wisconsin Chapter of the American College of Emergency Physicians Business Meeting, MECCA, Milwaukee.

Mar 29: Wisconsin Orthopaedic Society Business Meeting, MECCA, Milwaukee.

Mar 29: Wisconsin Otolaryngological Society Business Meeting, Marc Plaza, Milwaukee

Mar 29: Wisconsin Society of Pathologists Business Meeting, MECCA, Milwaukee.

Mar 29: Wisconsin Radiological Society Business Meeting, MECCA, Milwaukee.

Mar 29: Wisconsin Surgical Society Business Meeting, MECCA, Milwaukee; and Dinner, University Club.

Apr 17-18: *Third Annual St Mary's Symposium on Burns and Critical Care.* Presented by St Mary's Hospital Burn Center, Milwaukee. Format: Combination of didactic lectures and workshops, separate and combined sessions for nurses and physicians. Cochairmen: Burton A Waisbren, MD and George E Collentine, MD. Info: St Mary's Burn Symposium, 2323 N Lake Drive, Milwaukee, Wis 53211.

Apr 19-20: *Therapeutics 1980,* University of Wisconsin Clinical Science Center, Madison. Fee: $110. Approved 9 credit hours in Category I for PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

Apr 28-30: *A Seminar-Workshop on Arthrography and Skeletal Trauma,* The Sheraton Inn, Madison. Fee: $250 seminars and workshops; $200 seminars only. 21 hours Category I of AMA, American College of Radiology applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

May 2-3: *Vascular Surgery Symposium,* The Wisconsin Center, Madison. Fee: $145. Approved 12 credit hours in Category 1 for PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

May 17-18: Workshop on Practice Management, Red Carpet Inn, Milwaukee. 11½ hours AAFP and AMA Category I credit. Info: AAFP, 1740 West 92nd St, Kansas City, MO 64114.

May 30: *The Family in Primary Care,* Wisconsin Center, Madison. Fee: $50. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

Jun 11-14: *Cardiac Rehabilitation: Critical Issues and Practical Concerns,* Red Carpet Inn, Milwaukee. Eligible for AMA Category I credit; UW-Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

Jun 19-20: *Symposium on the Diabetic Pregnancy and the Infant of the Diabetic Mother,* Wisconsin Center, Madison. Fee: $130. 12 credit hours of PRA-AMA Category I. AAFP prescribed credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

June 26-28: Wisconsin Academy of Family Physicians Annual Scientific Assembly and Congress of Delegates, Chula Vista Resort, Wisconsin Dells, Wis. Info: WAFP, 850 Elm Grove Rd, Elm Grove, Wis 53122.

AMA Department of Negotiations presents

SEMINARS ON KNOWLEDGE AND SKILL DEVELOPMENT IN NEGOTIATIONS

March 13-15,1980

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution.* Hyatt Regency Hotel.
Phoenix, Arizona

April 18-19, 1980

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution for Hospital, HMO, Academic and Other Salaried Physicians.* Cherry Hill Holiday Inn.
Cherry Hill, New Jersey

September 12-13, 1980

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution with Health Planning and Other Government Agencies.* Radisson-Muehlebach Hotel.
Kansas City, Missouri

June 12-14, 1980

Advanced seminar for physician negotiators: *Dynamics of Conflict Resolution.* Burlingame Hyatt House.
Burlingame, California
(near San Francisco International Airport)

As an organization accredited for continuing medical education, the AMA Council on Continuing Physician Education certifies that the continuing medical education activities designated Category I meet the criteria for Category I on an hour-for-hour basis for the Physician's Recognition Award of the American Medical Association.

For more information on above educational programs, contact AMA Department of Negotiations, 535 North Dearborn St, Chicago, Illinois 60610, or call 312/751-6652.

AMERICAN HOLISTIC MEDICAL ASSOCIATION'S
6th Scientific Program

HEALTHY LIFESTYLE: ACHIEVING FULFILLMENT

March 14-16, 1980
Sheraton Twin Towers
Orlando, Florida

Approved 13 credit hours in Category 1 for AMA.

Keynoter: *Joseph A Pursch, MD,* Chief Alcohol Rehabilitation Service, Long Beach Naval Hospital plus 12 other authorities. Workshops and lectures on *Practical Medical Advances.*

Info: AHMA, route 2, LaCrosse, Wis 54601 or tel 608/786-2660.
pl/80

NATIONAL MEDICAL SPECIALTY SOCIETIES

1980 Meeting Dates/Sites

Feb 16-20: American Academy of Allergy, Hilton Hotel, Atlanta, Ga.
May 9-13: American College of Cardiology, Houston, Tex. Info: W D Nelligan, 9111 Old Georgetown Rd, Bethesda, MD 20014.
Apr 14-18: American Association of Pathologists, Grand Hotel, Anaheim, Calif.
Apr 20-25: American Occupational Medical Association, Detroit Plaza Hotel, Detroit, Mich.
Apr 28-May 2: American Pediatric Society, Convention Center, San Antonio, Tex.
May 5-8: American College of Obstetricians and Gynecologists, New Orleans, La.
May 3-9: American Psychiatric Association, Hilton Hotel, San Francisco, Calif.
May 15-18: American Society of Internal Medicine, Hyatt Regency, Washington, DC.
May 18-22: American Urological Association, Hilton Hotel, San Francisco, Calif. (Annual Meeting)

GREAT LAKES SKI-IN: SURVIVAL IN EMERGENCY MEDICINE

A course on Management, Legal and Financial Aspects of EM and EMS Impact

Playboy Club, Lake Geneva, WIs
February 18, 1980

Sponsored by Wisconsin Chapter, American College of Emergency Physicians

8 hours Category I credit of ACEP/AMA and AAFP. Fee: $85-$100.

Info: J Gennrich, MD, Wisconsin ACEP, 10201 W Lincoln Ave, Milwaukee, Wis 53227. Tel: 414/545-5568.

NUCLEAR CARDIOLOGY for the PRACTICING PHYSICIAN

Third Annual Symposium arranged by Dr Harold L Brooks and Dr Jagmeet S Soin at the Medical College of Wisconsin

July 27—July 30, 1980

The Hilton Head Inn at Sea Pines Plantation, Hilton Head Island, South Carolina

Course is designed to bring the state of the art in Nuclear Cardiology to the practicing physician in community hospitals throughout the nation, specifically to physicians specializing in nuclear medicine, cardiology, and residents, fellows, and technologists. Program will consist of lectures, detailed panel discussions with audience participation and on-site demonstrations of current equipment.

For information contact—

Dr Jagmeet S Soin, Division of Nuclear Medicine, Milwaukee County Medical Complex, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

1980 Others

Mar 9-15: American Society of Contemporary Ophthalmology, joint meeting with international Glaucoma Congress, Sheraton Twin Towers, Orlando, Florida. Up to 50 CME hours, Category 1. Info: John Bellows, MD, ASCO, 6 North Michigan, Room 1110, Chicago, Ill 60602.

12/79,1-2/80

Mar 9-15: American Society of Contemporary Medicine and Surgery, 15th annual meeting. Sheraton Twin Towers, Orlando, Florida. Up to 40 CME hours, Category 1; acceptable for 25 prescribed hours, AAFP. Info: John Bellows, MD, ASCMS, 6 North Michigan, Room 1110, Chicago. Ill 60602. 12/79,1-2/80

1980 AMA

Mar 13-15: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Phoenix, Ariz. See details elsewhere in this section.

Apr 17-18: AMA 33rd National Conference on Rural Health, Boston, Mass. See details elsewhere in this section.

Apr 18-19: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Cherry Hill, New Jersey. See details elsewhere in this section.

June 12-14: *AMA Seminar on Knowledge and Skill Development in Negotiations.* Burlingame, Calif. See details elsewhere in this section.

Sep 12-13: *AMA Seminar on Knowledge and Skill Development in Negotiations.* Kansas City, Mo. See details elsewhere in this section.

TELEPHONE CONFERENCES—1980

Thursday, April 3, 10, 17 & 24, 1980—7:30am

Cancer Management

Apr 3: Breast Cancer Management—Update, *Thomas E Davis, MD*

Apr 10: Interferon and other Immunomodulators in Cancer, *Ernest C Borden, MD*

April 17: Management of Colon-Rectal Cancer, *Hugh L Davis Jr, MD*

Apr 24, 1980: Newer Concepts in Bladder, Prostate, and Kidney Cancer, *Dennis L Citrin, MD*

Info: Nancy Vilbrandt, Dept of CME, 610 N Walnut, Madison, Wis 53705, tel: 608/263-2860.

CHILDREN'S HEALTH AND SAFETY CONFERENCE
Friday, February 29
War Memorial Center
750 N Lincoln Memorial Drive
Milwaukee, Wisconsin
Sponsored by
- State Medical Society of Wisconsin
- Center for Public Representation
- Center for Consumer Affairs—UW-Extension
- Wisconsin Chapter of the American Academy of Pediatrics

Conference will provide a unique opportunity to examine the policies and politics that impact on the health and safety of today's young people. It will focus on the responsibilities of both the public and private sectors. Parents, educators, healthcare and social service providers, policy makers, children's advocates, youth, and all who are interested in children are encouraged to attend.

Keynote address
- **Lisbeth Bamberger Schorr** Chairperson, National Select Panel for the Promotion of Child Health; Consultant, Children's Defense Fund; Member of Board of American Academy of Pediatrics

Luncheon address
- **Richard H De Lone** Former Associate Director, Carnegie Council on Children; Author, *Small Futures: Children Inequality, and the Limits of Liberal Reform;* Executive Vice President, Corporation for Public/Private Ventures

MDs participating
- Darold A Treffert, MD,* Fond du Lac
- Paul Harkins, MD,* Marshfield
- Perry Henderson, MD,* Madison
- Charles Schoenwetter, MD,* Madison
- Larry Siegal, MD,* Waukesha
- Roland Herrington, MD,* Milwaukee
- Ben Peckham, MD,* Madison
- Gerald Porter, MD,* Marshfield
- Kathryn Nichol, MD,* Madison
- Earl Shrago, MD, Madison

*SMS members

Registration fee: $20 (make check payable to UW-Extension, and mail to Center for Consumer Affairs, UW-Extension, 929 North 6th Street, Milwaukee, Wis 53203.

For further info: Paul Haussman, Center for Consumer Affairs (414) 224-4177; or Beth Jones, State Medical Society (608) 257-6781; or Patricia Mapp, Center for Public Representation (608) 251-4008.

33rd National Conference on Rural Health

Boston, Mass/Sheraton Boston April 17-18, 1980

Sponsored by AMA in cooperation with AHA, ANA, APhA and others

Seven continuing medical education courses placing particular emphasis on the needs of the rural practitioner. CME courses meet the criteria for Category 1 accreditation on an hour-for-hour basis for the Physician Recognition Award of the AMA.

Courses:

—*Common Poisoning Emergencies.* Instructor: Frederick H Lovejoy, MD, Children's Hospital Medical Center, Boston, Mass.

—*Sportsmedicine in Rural Schools.* Instructor: J M Ingalls, MD, Paris Community Hospital, Paris, Ill.

—*Plastic Wound Closure Techniques for the Primary Care Physician.* Instructor: William M Champion, MD, Plastic Surgery Associates, Inc, Seattle, Wash.

—*Nutritional Assessment and Management in Rural Areas.* Instructor: George Blackburn, MD, New England Deaconess Hospital, Boston, Mass.

—*Agricultural Health Problems.* Instructor: Kelley J Donham, DVM, Institute of Agricultural Medicine, Department of Preventive Medicine and Environmental Health, University of Iowa College of Medicine, Iowa City, Iowa.

—*Primary Management of Severe Head Trauma.* Instructor: David G Piepgras, MD, Department of Neurologic Surgery, Mayo Clinic, Rochester, Minn.

—*Hand Amputation: How to Help a Patient and Microsurgeon.* Instructor. Allen Van Beek, MD, Division of Plastic Surgery, Section of Microsurgery, Southern Illinois University School of Medicine, Springfield, Ill.

Physicians wishing further information about the course schedule should call Mrs Barbara Chapman (312/751-6604 or 312/787-6695) or Mr Dale C Smith (312/751-5997 or 312/525-1280), or write to the Department of Community Health Systems, AMA, 535 North Dearborn St, Chicago, Ill 60610.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

MEDICAL BOARD OUTLINES DUE PROCESS FOR CME CASES. The Medical Examining Board, on December 14, mailed license renewal notices to all physicians who had been delinquent in submitting the required 30 credits of continuing medical education to the Board for 1980-81 re-registration. **Physicians are not to construe this renewal notice as a waiver of the CME requirement.** Physicians who return the renewal notice to the Board without proof of 30 credits of CME will not have their licenses re-registered until they do so. In order to comply with due process, the board has found it necessary to allow physicians until March 14 to submit CME credits for 1980-81 re-registration. Physicians who do not wish to comply and plan to de-activate their license should so notify the Board. Physicians who have moved within the last year and who did not report the change in address to the Board should contact the Board at (608) 266-2811 if they failed to receive their license renewal notices.

The due process timetable is as follows:

JANUARY 2, 1980—Certified letters will be mailed to all noncomplying physicians stating that they have failed to submit the necessary 30 CME credits and thus are not able to re-register to practice. Failure to submit evidence of 30 credits immediately will result in the commencement of a legal action to terminate all rights and privileges conferred by the license.

FEBRUARY 1, 1980—Followup certified letter will be mailed.

FEBRUARY 29, 1980—List of noncomplying physicians will be referred to the State Office of Consumer Complaints.

MARCH 14, 1980—Formal complaints will be issued against noncomplying physicians by the Board.

The State Medical Society, through the *Wisconsin Medical Journal*, MEDIGRAM and other communications, has reminded its members throughout 1979 of the CME requirement and a final reminder letter to SMS members was mailed December 28.

SUPER-RULE. Elsewhere in this issue Brian Jensen, director of the SMS Physicians Alliance Division, summarizes the development of the "Super-Rule"—the first effort by the State Department of Health and Social Services and the Wisconsin Legislature to codify the rules of the Wisconsin Medical Assistance Program (WMAP).

TAX TIPS FROM SMS SERVICES. With 1979 drawing to an end, SMS Services, Inc reminds physicians of the following recent changes in federal tax laws:

* The Internal Revenue service has raised the standard mileage rate for business use of an automobile from 17¢ to 18.5¢ per mile for the first 15,000 miles and 10¢ per mile for mileage in excess of 15,000. THE CHANGE IS RETROACTIVE TO JANUARY 1, 1979.

* The interest rate charged for late payment of federal taxes will jump from 6 percent to 12 percent effective February 1, 1980.

* Effective January 1, 1980 the amount of individual payroll subject to social security tax will be $25,900, up from the 1979 base of $22,900. Tax rates will stay the same at 6.13 percent for employees and employers and 8.1 percent for those who are self-employed. ▪

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WISCONSIN MEDICAL JOURNAL

FEBRUARY 1980

• The case of the 'belegaled' professional/President Treffert • Continuing medical education in the community hospital/Doctor Pohlmann • Cancer of the esophagus/Doctors O'Connor, Watson, and Weisel • Health planning major topic at Council meeting • Summaries of resolutions to be presented to House of Delegates at Annual Meeting, March 27-29, Milwaukee

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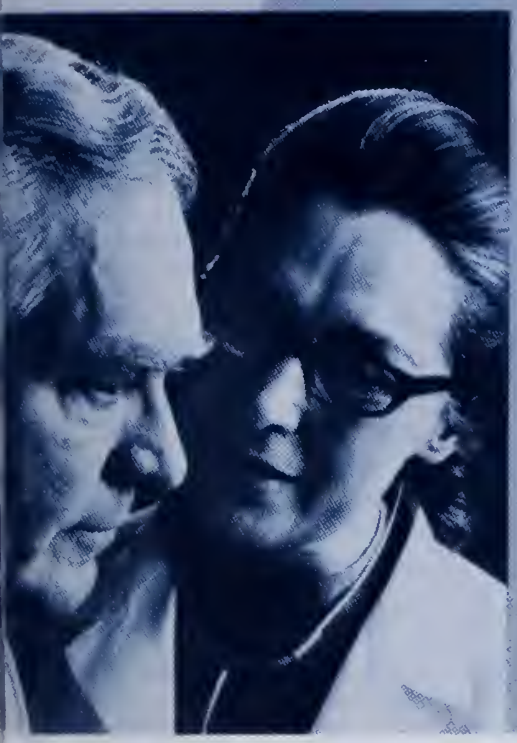

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*, severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients.* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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Created by the Territorial Legislature in 1841

Representing 4,700 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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President's Page

Darold A Treffert, MD

The case of the "belegaled" professional

Case History:

This 138-year-old professional comes in with complaints of increasing fatigue, lassitude, mild confusion, some irritability, and early personality changes. Once an exceedingly proud and fiercely independent person, in recent years the patient has become less assertive, more defensive, tense, and intermittently depressed. He senses himself as being increasingly angry and frustrated which he handles at times with lashing out, but at other times becomes more withdrawn, ruminative, sullen, and introverted. He feels increasingly overworked, overwhelmed, less appreciated, and at times misunderstood. He feels those around him have become more demanding, more critical, and at times frankly adversarial. The rumination and defensiveness have led to decreasing productivity. He spends increasing time justifying and defending himself. Cynicism has replaced a sense of humor and pessimism has replaced a formerly good sense of perspective. Still very busy, highly skilled and obviously competent and valuable, these self-doubts have led to a sense of increasing futility and inability to cope. While there are no well crystallized delusions, there are numerous ideas of reference about intervention in his professional and personal life by others; and at times the patient is suspicious that the government, if not plotting against him, at least is not treating him at all fairly.

Inspite of these symptoms the patient very much wants to feel better and more comfortable; he is very well motivated toward change. He seems willing not to merely blame others for his present predicament but to see in what manner he might have contributed to some of these present perceptions and to change those things. His history of having done well in the past, his considerable strengths, his value to the community and those around him, and his increasing openness to change, along with his basic pride in himself, bespeak a good prognosis.

Treatment: APC (Active Political Confrontation)

While Oliver Wendell Holmes advised physicians "not to dabble in the muddy sewer of politics," doctors can affect the stream of things if they care to be, dare to be, and take the time to be, active participants in the political process. Understanding the political process, the way it really works rather than the way we think it works, is helpful as a necessary first step if the doctor is going to be effective in that process and is going to avoid the frustration, anxiety, cynicism, or fatalistic resignation so often seen in the doctor who, contrary to Holmes' admonition, does dabble in politics. A prescription for such activity would have the following ingredients:

(1) ***Get involved.*** Physicians are so busy doing urgent things that they neglect important things. An important thing is helping to mold our future. Neither a massive public relations job nor a costly lobbying effort will substitute for the actual intensive, intimate involvement of the doctor himself/herself in the day-to-day political process. In medicine some things cannot be delegated to our assistants; some things only the doctor can do. This is one of those things. No amount of shoulder shrugging, head shaking, or "ain't it awful" games with our colleagues will get the job done. Each physician should devote two hours a month personally to this activity at the local, state, or national level, or else, failing that, donate the equivalent of those hours' earnings to organizations, persons, or legislators willing to work on the doctors' behalf.

(2) ***Get to the key decision makers.*** No legislator, or governor, can possibly be conversant with each of the over 2000 bills introduced in a typical state legislative session. In some instances legislators depend upon colleagues or advisors knowledgeable in a particular area to guide their

vote; and in other instances frank party or political considerations become paramount. In either event there are a few key persons eminently influential in the design and passage of legislation with, in fact, more influence than a lobbyist or even a constitutent. That person may be: (a) a legislator working as a peer with his colleagues with obvious advantage, (b) a budget analyst from the legislative fiscal staff, Governor's office, or some State Department, (c) a powerful Senate or Assembly majority leader or caucus leader, or (d) chairman of some key committee such as Finance. It is crucial to find out who those few persons are, inside or outside the Legislature itself, and gain access to them. A great deal of time and effort needs to be spent in identifying those six or eight powerful persons crucial and determinant in specific areas. Then, having identified them, the physician must gain access to them for education and persuation.

(3) ***Begin early.*** Good prenatal care doesn't begin on the delivery table. Good prepassage care doesn't begin at the public hearing or on the eve of the vote. Political activity occurs before, between, during, and after the session itself. Insisting on input when a bill is being drafted is as determinant to outcome for legislation as the first trimester is determinant to outcome in pregnancy. The public hearing or eve of the vote may simply be too late. Someone must be constantly attentive to the whole legislative cycle. Mounting a gigantic effort at or after the public hearing is nowhere nearly as effective as influencing the process far prior to that point.

Public hearings serve a useful function—public information—but have little to do with final outcome. Legislative opinion is usually shaped by that time, and if not, that forum is not where opinions are shaped anyway. For purposes of public information we do need to send our best, most persuasive, most succinct communicators (again the physician himself/herself), but we ought not to lean very heavily on outcome or flavor of a public hearing. Packing a hearing room may make us feel better but has a very short-lived impact. If we direct some effort at that, and sometimes strategically we must, such effort cannot be in lieu of more constant, earlier effort. Busloads of persons at the hearing is simply not a substitute for ongoing, constant political activity.

(4) ***Use your lobbyist to work with you, not for you.*** Just as the public hearing has somewhat of a placebo effect, so many physicians, having paid some money or dues to hire a lobbyist, assume their political chores are done. Not so. A lobbyist's task is not to get votes, but to get access, for the physician, as outlined above. The lobbyist knows who those key persons are, knows the innuendo of political power structure, and knows how to gain access to those persons. The legislator today is a sophisticated professional, not a "knife and fork" politician who can be dined and dazzled. The lobbyist today works to get his client, the physician, essential access at the essential time. It is up to the doctor to use that access once gained.

(5) ***Forget the form letters and petitions.*** Petitions make the constituent feel better but rarely influence outcome. What is influential is a personal letter—short, succinct, persuasive—from that legislator's own constituent. That constituent needs to be the physician himself/herself. If also (but not in lieu of the doctor's letter) there can be letters from patients or other interested persons (including the physician's family who also are constituents), those can be helpful, too. Letters are preferable because they, unlike phone calls, do not come at inopportune times, can be read at the legislator's convenience, and become a permanent part of the bill jacket and can be reviewed at intervals when the bill has a significant movement. Form letters—forget it. Organization letters—not nearly as important as personal letters from the constituent—the doctor. Personal letters are what count.

(6) ***Doctor and legislator/one-on-one.*** Except for getting the legislator elected, there is no better investment of time than getting to know your legislator personally over lunch or coffee at a time when you don't have an axe to grind, bill to explain, or gripe to air. It gives you a chance to hear the legislator's problems and perspective rather than his merely hearing your side of things. Such an effort in a quiet moment will get the physician, at a crisis moment, the same personal and more receptive attention that a patient gets who has had some prior contact with the doctor, such as an annual physical, rather than appearing for the first time in a crisis in the emergency room.

(7) ***Don't just vote for the candidate you want elected, help elect him.*** The most effective measure of getting good legislation is electing good legislators and governors. The proper time to influence outcome in the halls of the Legislature is *before* legislators are elected. That means more than voting; that means money for campaigns, hosting get-acquainted coffees, contributing and attending fund raisers, distributing literature or whatever—participating, not just contributing.

Yet this is an activity doctors avoid, sometimes because we are too busy, sometimes because we feel awkward, and sometimes because we feel such activity is sinful, tainted, or unimportant. There is nothing sinful, tainted, or unholy about getting those persons elected whom we feel are

the best candidates. There is nothing "special interest," in the negative connotation of that phrase, about supporting and working to get elected those persons we feel are the most qualified, most knowledgeable, and most representative of good public policy considerations. In that sense and in a very good sense, each and every voter, when he/she votes, casts a "special interest" ballot. There is nothing tainted about that. That is the cornerstone of the democratic process.

(8) ***Be involved in the entire political process.*** If I could prescribe the single thing that would help us most in the political stream of things, it would be to have at least one physician elected to each legislative body. The parliamentary and peer influence advantages are obvious. I really think we should make that a priority and practical objective—advising, helping, and making it possible for those doctors so inclined to become legislators, congressmen, and governors.

For a whole lot of reasons that likely will not occur. The inescapable and necessary alternative is for each and every physician to become actively, intimately involved in the political process in the way outlined above. I have been impressed not only with how the political process works but also with the fact that it does work. Rather than being the mere victims of a health system designed by persons who do not understand it, physicians can help be architects of the system because they do understand it and if they are willing to share that understanding and that expertise with politicians.

In my experience legislators, for the most part, are sophisticated, practical, interested, and available. They are, however, under incredible pressure from a whole variety of constituent, special interest, and political considerations; and the physician has to be willing to compete with those other important considerations. While expecting no special handling because he is a physician, he cannot, on the other hand, refuse to compete just because he is a physician.

With the elections upon us, there is no better time to do so than now. I hope this brief look at the political stream of things helps. It will help to become less of a "belegaled" profession. ■

NEWS YOU CAN USE

HEALTH PLANNING JARGON DEFINED. The emergence of "health planning" in the United States and Wisconsin has created a new vocabulary of bureaucratic words and phrases which many physicians find confusing. For your reference, explained below are three health planning terms frequently referred to in SMS publications.

• ***Certificate-of-Need*** (CON)—Passed by the Wisconsin Legislature in 1977, this law requires prior approval from the Department of Health and Social Services Bureau of Needs Review before a hospital or nursing home can lease, construct, or purchase a facility. Additionally, any substantial change in service or the purchase of clinical equipment in excess of $117,000 also requires CON approval from the State. In a physician's office the law applies only to the purchase of equipment costing over $117,000, or $150,000 for two or more related pieces of equipment.

• ***Appropriateness Review***—Health planning agencies have been given a new and potentially powerful tool to review the "appropriateness" of existing institutional health services. The regulations now require each Health Systems Agency to review all institutional health services in the area at least every five years and to make recommendations to the Department of Health and Social Services concerning the appropriateness of the services offered. Planning agencies may provide their findings on either an institution-specific or an areawide basis. States may then impose sanctions on institutions which do not meet the (yet to be written) standards but are not required to do so under federal law.

• ***Decertification Rule Development***—These administrative rules currently are being drafted pursuant to the Wisconsin Certificate-of-Need law. Sometime in 1980 Wisconsin will be able to "decertify" any of six specialized hospital services: (1) cardiac catheterization/open heart, (2) radiation therapy, (3) hemodialysis, (4) kidney transplants, (5) high-risk neonatal units, and (6) computed tomography, unless they meet established criteria of need, are reasonably accessible, and are provided in a manner which is consistent with community-defined quality-of-care standards. Before actual decertification, the Department of Health and Social Services must work with the institution in an attempt to bring the service up to par. Sanctions for noncompliance with this program as with the Certificate-of-Need are substantial.

Editorials

Editorial Director: WAYNE J BOULANGER, MD

Ticrynafen (Selacryn®)

In early January the Editorial Board accepted a paper by Doctors Terrence Boland and Philip Dahlberg of La Crosse. It was entitled "Ticrynafen Associated Acute Renal Failure." The paper detailed two cases of acute renal failure following the use of ticrynafen (Selacryn®—SmithKline & French).

In mid-January SK&F recalled Selacryn® because it was shown that it can cause significant hepatic injury. A few instances of severe hepatic damage and death have been reported. Selacryn® was one of only 14 new drugs approved by FDA in 1979.

Since the sale of Selacryn® has been suspended, the publication of the paper on renal failure would be moot. However, cognizance of this adverse renal reaction should be taken in addition to the repeated hepatic injury.—VSF

Geriatric politics

As we enter the election year and follow the making of the President, 1980, some thoughts on the candidates emerge. The media give far greater attention to the activities of Senator Kennedy than they do to say, George Bush. The difference might charitably be attributed to "charisma."

Another foible of the media is invariably to mention the age of Ronald Reagan when discussing his candidacy. The automatic labels of "right wing" or "conservative" are also gratuitously applied. John Brown is glibly referred to as a "flake." Connally—"wheeler-dealer". Phillip Crane or John Anderson are scarcely mentioned at all.

President Carter remains presidential at least in the eyes of Gerald Rafshoon or Jody Powell. Senator Howard Baker is too senatorial to be presidential.

Governor Reagan's age as an issue may be less of a handicap than some of the crosses born by other candidates. This brings to mind memories of other chiefs of state or political figures who reached the pinnacle of their power as senior statesmen. Among them are Conrad Adenauer, "Der Alte", who was 84 years old in 1960, Charles De Gaulle, 70 in 1960, Winston Churchill, 70 in 1944.

While not exactly presidential candidates, Francisco Franco was 73 in 1965 and Georges Clemenceau, the "tiger of France," was 77 in 1918. Mature statesmen tend to have an established and somewhat predictable personalities and are less subject to abrupt changes in political philosophy. Consistency is the mark of elder statesmen.

Which brings back to the subject of Ronald Reagan's age which may be an asset rather than a liability. At least some of us like to have a president older than we are.

Ben Franklin was 70 years old in 1776, and that was just the beginning. —RAM

Medical Relief in Indochina

In mid-November a Milwaukee based Indochina relief group was organized. Since that time the group has raised over $200,000 in voluntary contributions. Simultaneously, The Medical College of Wisconsin has organized a medical team to treat refugees, primarily from Laos, who are in a camp in northern Thailand. Doctor William Coleman, Professor of Preventive Medicine at the College, spearheaded the medical campaign.

In December Doctor Coleman, along with Doctors John Arkins and Charles Junkerman, Professors of Medicine at The Medical College of Wisconsin, went to Thailand as an advance team. In early January the first medical relief team left for the camp and small hospital. It is anticipated that the Wisconsin Indochina Refugee Relief Group will send out nine other team members between mid-January and mid-February. Thereafter, a team will be sent out each month for the next year.

The teams consist of faculty members from The Medical College of Wisconsin, which forms

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

the nucleus, along with medical students, nurses, nutritionists, and other medical volunteers.

The situation along the Laotian border is comparable to the more publicized Cambodian catastrophe, but the refugees in the north were driven out of their homeland even at an earlier date.

Medical volunteers who are interested in offering their services or other contributions are invited to contact Doctor William Coleman, Chairman of the Wisconsin Indochina Refugee Relief Incorporated at PO Box 26509, Milwaukee, Wisconsin 53226.—VSF ■

NEWS YOU CAN USE

HEW LAUNCHES SECOND OPINION DRIVE. The US Dept of Health, Education, and Welfare (HEW) in January began a nationwide information campaign to encourage people to get a second medical opinion before undergoing nonemergency surgery. The campaign will include radio and television announcements, brochures, posters, and a toll-free telephone hot line through which patients can get the names of physicians willing to give second opinions. The campaign, being conducted by HEW's Health Care Financing Administration which administers Medicare and Medicaid, will also encourage patients to discuss frankly with their physicians how to obtain a second opinion for nonemergency surgery. HEW said first-year results of a three-year demonstration project in New York by Blue Cross/Blue Shield of Greater New York show that in 31% of 1,464 cases recommended for surgery, the need for surgery was not confirmed by physician consultants giving second opinions. Medicare pays for second opinions for surgery nationwide, and Medicaid covers second opinions in most states. The toll-free telephone hot line numbers are: (800) 638-6833 and in Maryland (800) 492-6603.

COLLECTION SERVICE BENEFITS MEMBERS. Eighteen months ago, after careful investigation, the SMS Services, Inc endorsed a collection service offered by the I C System, Inc and recommended it to SMS members as an effective, ethical, and economical system for collecting delinquent accounts. During 1979, I C System, Inc collected over $463,000 for SMS members; the number of medical practices in Wisconsin using the service grew to 367, and the number of state medical societies endorsing the service rose to 10. This program is unique because you retain full control at all times. All money is paid directly to you by the patient. You alone can make adjustments, or accept installment payments, whenever individual cases indicate such a procedure on your part is desirable.

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Letters

"Brain death" legislation

In 1978 and 1979 brain death legislation was before the Wisconsin Legislature. I have heard from talking with physicians around the State that legislators were not prompted to act because it was felt that there was no need. Wisconsin physicians have not been supportive of brain death legislation. In other words, the law has not been felt to be needed. Unfortunately, this reluctance to act in an area of medical jurisdiction has resulted in another case in which a person already dead was given prolonged support by life support systems. On December 16, 1979 an infant was allowed to be removed from artificial support. The patient had been on a respirator and brain-dead since mid-November. Five weeks of unnecessary treatment was given and only concluded when the case was presented to Circuit Court Judge Daniel Moeser. The judge urged the Wisconsin Legislature to do something about defining death. "In these times of advanced medical technology it is unacceptable to this court to be bound by an outdated common law definition of death." If physicians do not rally behind an acceptable law, we will continue to demonstrate a lack of responsibility to the medical community of Wisconsin.

The American Medical Association adopted a board of trustees report on "brain death" legislation in its recent Hawaii meetings. The new AMA model legislation has now become the policy of the American Medical Association. Under the model bill, a person who had sustained either "irreversible cessations of circulatory and respiratory functions" or "irreversible cessation of all functions of the entire brain" shall be considered dead. I urge those physicians who have in the past felt that a legislative resolution is not necessary to now reexamine their thinking so that we can establish for the State of Wisconsin uniform medical practice. It is unfortunate that this child continued to receive support until the courts could act. There obviously is a need for a uniform statement in the State of Wisconsin.

—**Philip M Green, MD**
Marshfield, Wisconsin

The Editors would like to encourage physicians to contribute to the LETTERS TO THE EDITOR section. We think it's good to have physicians ventilate their frustrations as well as opinions. In short, we want to make this a lively and spirited section as well as an informative and educational one. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Responses to Doctor Blount and CME

The first portion of Doctor Blount's excellent and interesting letter (*WMJ*, January 1980) expresses well my feelings and opinion about continuing medical education as it presently functions. I believe also that federal, state, and subsidiary medical bureaucrats are taking over, but also medical bureaucrats. These are supposed to be the "sincere leaders of medical education;" but in our specialty, one sees the same names and faces on junkets scheduled for all over the world. The same courses could well be held—better be held—in some central location at little or no expense to the doctor or the taxpayer, instead of Hawaii or Timbuktu. To me the whole idea is nauseating (the CME procedures and re-certification); and it is a reflection on the integrity and dedication of the many fine doctors in our state and in the country.

I do not feel Doctor Blount's (and the orthopedists') solution to the problem is feasible; but if CME continues to exist as a mandatory discipline, I cannot come up with a reasonable and practicable solution myself and, therefore, can't be too critical. I personally feel that I should like to continue as a free medical spirit, continue to attend courses and meetings as I have in the past 42 years, and not be dictated to as to how and

continued on page 14

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when it should be done by either political or medical bureaucrats.

—**Harlan M Levin, MD**
Janesville, Wisconsin

* * *

Doctor Blount's letter (*WMJ*, January 1980) is certainly timely and appropriate. I totally agree with his approach to the problem as suggested for the orthopedic surgeon. It becomes a more difficult problem to evaluate performance and knowledge of nonsurgical physicians and especially those of very limited type practices (office, etc). Certainly the achievement of "brownie points" in whatever manner is better than no attempt at all.

—**M C F Lindert, MD**
Milwaukee, Wisconsin

* * *

I certainly agree that continuing education has been a policy of the profession throughout its entire history. However, there are some who need prodding.

—**Melvin F Huth, MD**
Baraboo, Wisconsin

CME credits . . . continued

It was with some regret that I noted the newspaper comments relative to the "1000 state doctors who would *lose* their licenses." I suspect that among them are a good many others who do so voluntarily. The Mayo Clinic where I received my surgical training has for many years retired the surgeons at age 65, the internists at 70 with rare exception. With this concept I am in accord. I am reluctant to have a 65+ lawyer, airline pilot, accountant, or any professional in a key situation that might involve my health or personal living.

As far as the CME program I am certain that most share my doubts about its intrinsic value in keeping physicians well versed in the changes of medicine. Among my peers in age there are a few who have elected to keep their license by gathering the necessary credits. There is a certain amount of recognized humor among them when they indicate what they have done. The courses or other activities often bear little relationship to their field of interest which essentially defeats the intent. I hope in the interests of the future that some reevaluation of the CME in terms of relevancy to the special field of practice can be made.

—**Samuel B Harper, MD**
Madison, Wisconsin

* * *

In the past three years there have been no CME courses in my specialty (Public Health) available anywhere in the Midwest. I was certified in 1950 by examination by the American Board of Preventive Medicine. I retired in 1971.

Except for three years in the Army in World War II, I have devoted my entire career to protecting and promoting the health of the entire community—at considerable financial sacrifice.

This dishonor the State of Wisconsin does to me I think I do not deserve.

Some months ago I requested an audience with the State Medical Examining Board. I received a form letter stating CME requirements.

—**Charles K Kincaid, MD**
Madison, Wisconsin

Editor's note: Doctor Kincaid is former City Health Officer, Madison. ■

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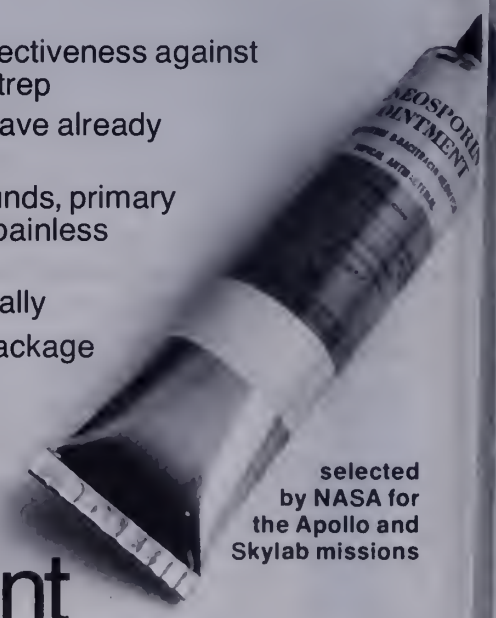

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Nutritional status of cancer patients

The cancer patient is considered to be at high nutritional risk during the course of the disease, and especially during cancer therapies.

Weight loss, often experienced by victims of various malignant neoplasms, may be primarily due to anorexia. Reduced food intake seems to result in part from altered taste and smell sensations. Other factors interfering with adequate nutrient ingestion may include alterations in the hypothalamic mechanisms of food intake, products of altered metabolism of nutrients, or simply a decreased desire to eat resulting from pain or depression in the cancer patient. Weight loss may be masked by fluid retention, which results in a stable or increased body weight while body wasting occurs.

Cachexia, defined as muscle and tissue wasting, is a form of malnutrition resulting from anorexia, altered metabolism, malabsorption syndromes, neoplastic invasion of the gastrointestinal tract, or protein-losing enteropathies. Body stores are depleted of essential nutrients at a time when nutrient needs, particularly calories and protein, may be increased. Immunocompetence may subsequently be greatly impaired.

The cancer patient's ability to withstand the stresses of treatment, as well as the course and outcome of the cancer therapies themselves, seems to be affected by the nutritional status of the host. The debilitating nutritional effects of antineoplastic therapies can often be minimized by careful coordinated nutritional intervention by the dietitian and the medical team. Most nutrient intake and utilization problems are reversible following treatment. A registered dietitian should be consulted prior to, or in early treatment stages to help improve the patient's food intake and/or nutritional status, and to intervene in the nutritional complications of therapies.

Surgical treatment of tumors imposes an additional stress upon the nutritionally compromised host in the form of postsurgical trauma.

The side effects of chemotherapy that are most devastating to the nutritional intake of the cancer patient are nausea, vomiting, diarrhea, and alterations in taste. The decreased food intake and reduced nutrient absorption consequently affect the nutritional status of the host. Awareness and anticipation of the various chemotherapeutic side effects, including specific drug-nutrient interactions of specific drug protocols, will alert the dietitian to probable nutritional consequences.

Effects of radiotherapy are specific to the site treated, and usually they are reversible after treatment. The patient's ability and desire to eat may be affected, especially during treatments to the head and neck area. "Mouth blindness" due to changes in taste thresholds, dry mouth with reduced salivation, mouth soreness, and difficulty in swallowing are common problems. The dietitian and other healthcare team members should assist the patient in maintaining adequate nutrition during radiotherapy.

Radiation to the abdomen and pelvic area has many nutritional implications related to the side effects of radiation enteritis on optimal nutrient utilization. Special dietary regimens may be required to maximize nutrient absorption, while minimizing the work load on the gastrointestinal tract for digestion.

Nutritional assessment of the cancer patient may include measurement of a variety of param-

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

eters. Those indexes most often evaluated are weight/height, recent weight changes, skinfold thicknesses, muscle mass, serum albumin, and lymphocytes. Secretory protein measurements are useful in determining visceral stores, while urine urea nitrogen and creatinine measures are helpful in evaluating nitrogen balance and skeletal muscle stores. Assessment of immune status also can contribute information in evaluating the patient's nutrition.

The nutritional intervention throughout the course of cancer and its treatments is aimed at minimizing nutritional side-effects such as reduced immunocompetence and negative nitrogen/kilocalorie balance.

—**Judy Reinke, RD, MPH**
Clinical Dietitian, University
of Wisconsin Hospital and Clinics
Madison, Wisconsin

Cancer programs

Please refer to the YELLOW PAGES of this issue for details on CME cancer programs. ■

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CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

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Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease . . . consider Quinamm . . . simple, convenient dosage—usually just one tablet at bedtime . . . can provide restful, welcome sleep without night leg cramps.

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Ventricular hypertrophy	Hepatic disease
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Diabetes mellitus	Gouty arthritis
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work/play—normal hemodynamic responses to exercise maintained.

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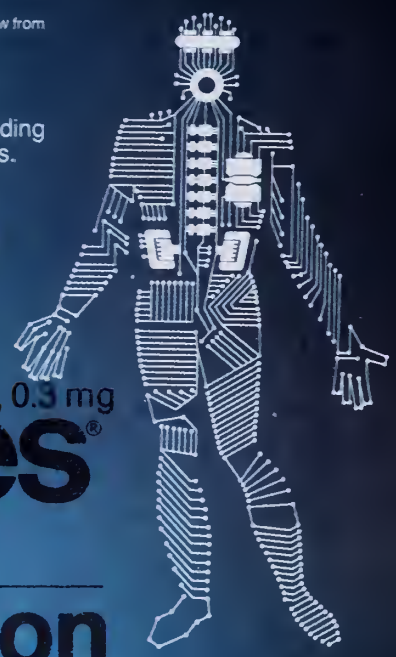
*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1 Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.



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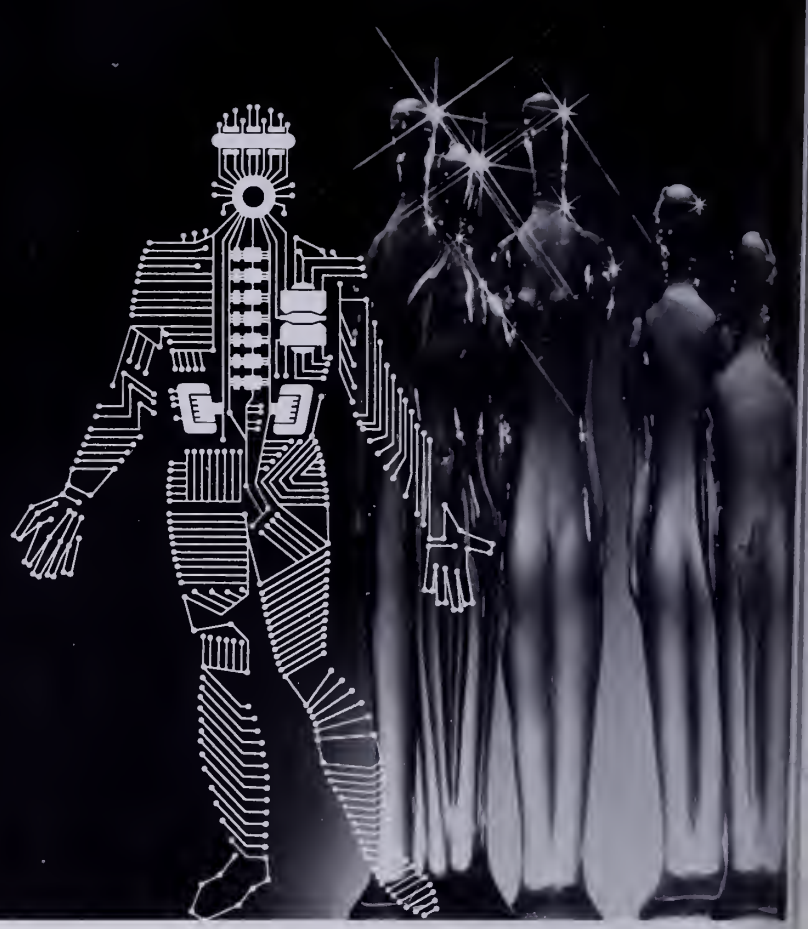

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at br fast and 0.1 mg at bedtime. Some patients may be from a starting dose of 0.1 mg at bedtime.

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Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

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Catapres®
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Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 longer.

Adverse Reactions: The most common reactions are dry mouth, drow sedation. Constipation, dizziness, headache, and fatigue have been Generally these effects tend to diminish with continued therapy. The reactions have been associated with the drug, some of them rarely instances an exact causal relationship has not been established.) The Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abno liver function tests; one report of possible drug-induced hepatitis with and hyperbilirubinemia in a patient receiving clonidine hydrochlor thalidone and papaverine hydrochloride. Weight gain, transient elevati glucose, or serum creatine phosphokinase: congestive heart failure, phenomenon; vivid dreams or nightmares, insomnia, other behavior nervousness, restlessness, anxiety and mental depression. Also gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not with a rash, impotence, urinary retention, increased sensitivity to alcoh itching or burning of the eyes, dryness of the nasal mucosa, pallor, gyn weakly positive Coombs' test, asymptomatic electrocardiographic ab manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, dimini sent reflexes and vomiting followed the accidental ingestion of Catapre hydrochloride) by several children from 19 months to 5 years of a lavage and administration of an analeptic and vasopressor led to c covery within 24 hours. Tolazoline in intravenous doses of 10 mg a intervals usually abolishes all effects of Catapres, (clonidine hydrochl dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is availabl (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 an available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

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Continuing medical education in the community hospital

Guenther P Pohlmann, MD, Milwaukee, Wisconsin

REQUIREMENTS FOR continuing medical education (CME) issued by the Wisconsin Medical Examining Board demand of each licensed physician the documentation of 30 hours of acceptable Category I programs during a two-year period preceding licensure renewal. This type of educational program should be well identified by topic and speaker and planned in advance on the basis of a recognized need. The effectiveness of its content and methods of presentation should be monitored, so should also be its impact on physicians' practice habits.[1] Individual hospitals and medical organizations have applied for, and in most instances received, accreditation for conducting their own Category I programs. This accreditation procedure has been conducted by the Commission on Continuing Medical Education of the State Medical Society of Wisconsin authorized for this function by the American Medical Association under whose auspices this concept and definition of categorized CME originated. Table 1 identifies the organizational nature of all accreditees and Table 2 the institutions/organizations accredited by the State Medical Society of Wisconsin as of Aug 15, 1979.

Should CME be decentralized to this degree, and can individual institutions be entrusted with this function? One could argue that the didactic talent and expertise residing in the larger medical centers could never be equalled by small community hospitals. On the other side, economic factors and the peculiarity of local clinical problems continue to argue in favor of this decentralized state of CME.[2] After all, recent estimates place the production cost of a CME program on an average of $10.00 per hour for Category I courses offered to a national audience. To this should be added the cost of transportation, lodging, meals, and loss of practice time.[3]

Beyond these two aspects, however, I would like to argue that CME has become the central component of a control system over the quality and cost of medical care without which any healthcare delivery system—be it hospital, a clinic or a specialty group of physicians—can no longer afford to function.[4] The purpose of this article, therefore, is to describe the structure and day-to-day operation of such a system which in a positive way can influence the quality and cost of healthcare through egalitarian participation and education of the physicians rather than by their subordination to structured authority and punitive action which may be beyond their control.

Table 3 provides a listing of the educational needs one may encounter in a healthcare system, such as a community hospital. Some of these needs may arise independently of the system as for instance the periodic review and updating of medical knowledge. Other categories reveal educational needs which are primarily related to the type of medical care delivered, the composition of patients and physicians who are intrinsic to the system.

Divergent demands for CME, such as the first three needs outlined in Table 3, can all be adequately met by a Category I type of program. This points out that a Category I program is not so much defined by the particular need which elicits its presentation but more so by its structure and the general appeal of its content.

Table 1—Wisconsin institutions and medical organizations accredited for Category I CME

Type	*Number*
Hospitals	45
Specialty organizations	26
County, state medical societies	1
Medical schools	2

From the Department of Clinical Services and Education, Columbia Hospital, Milwaukee. Doctor Pohlmann is Clinical Professor, Department of Medicine, Medical College of Wisconsin, Milwaukee. Reprint requests to: Medical Library, Columbia Hospital, 2025 East Newport Ave, Milwaukee, Wis 53211 (414/961-3300). Copyright 1980 by the State Medical Society of Wisconsin.

Table 2—Institutions and organizations accredited by the State Medical Society of Wisconsin—August 15, 1979

Antigo—Langlade County Memorial Hospital
Appleton—Appleton Memorial Hospital
St Elizabeth Hospital
Baraboo—St Clare Hospital
Beloit—Beloit Memorial Hospital
Chippewa Falls—St Joseph's Hospital
Cudahy—Trinity Memorial Hospital
Dodgeville—Memorial Hospital of Iowa County
Eau Claire—Luther Hospital
Sacred Heart Hospital
Elkhorn—Lakeland Hospital
Ft Atkinson—Ft Atkinson Memorial Hospital
Fond du Lac—St Agnes Hospital
Green Bay—Bellin Memorial Hospital
St Vincent Hospital
Kenosha—Kenosha Memorial Hospital
St Catherine's Hospital
LaCrosse—Gundersen Medical Foundation Ltd
LaCrosse Lutheran Hospital
St Francis Hospital
Madison—Madison General Hospital
Methodist Hospital
St Marys Hospital Medical Center
Marshfield—St Joseph's Hospital
Marshfield Clinic
Menomonee Falls—Community Memorial Hospital
Milwaukee—Columbia Hospital
Deaconess Hospital
Lutheran Hospital
Mount Sinai Medical Center
St Joseph's Hospital
St Luke's Hospital
St Mary's Hospital
St Michael Hospital
Monroe—St Clare Hospital
Neenah—Theda Clark Memorial Hospital
Oconomowoc—Memorial Hospital at Oconomowoc
Osseo—Osseo Area Municipal Hospital
Prairie du Sac—Sauk Prairie Memorial Hospital
Rhinelander—St Mary's Hospital
Tomah—Veterans Administration Medical Center
Watertown—Watertown Memorial Hospital
Waukesha—Waukesha Memorial Hospital
Wausau—Wausau Hospitals
West Allis—West Allis Memorial Hospital
West Bend—St Joseph's Community Hospital
Winnebago—Winnebago Mental Health Institute
Woodruff—Howard Young Medical Center

* * *

American Cancer Society-Wisconsin Affiliate
American Heart Association-Wisconsin Affiliate
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
The Racine Academy of Medicine
State Medical Society's Section on Ophthalmology
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Clinical Cancer Center
Wisconsin Dermatological Society
Wisconsin Health Care Review, Inc
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Otolaryngological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
Wisconsin Society of Radiation Oncologists

* * *

Marinette-Florence County Medical Society

* * *

AMA Accredited

Dept CME, Medical College of Wisconsin
Dept CME, UW Center for Health Sciences
Interstate Postgraduate Medical Association
The State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists

Table 3—Meeting the demands for CME through a structured program

Educational Needs	*Provisions*
(1) Automatic deficits arising out of general advances in medical knowledge and skills.	Didactic programs with the systematic rotation of topics by specialties or organ systems monitored by testing, audits or recertification examinations.
(2) Collective problems in diagnosis or therapy revealed by medical audit studies, medical record reviews of a specific physician group or healthcare system.	Didactic conferences should include illustration of the problem, indepth review of newer knowledge, and formulation of better approaches. Followup by reaudit and record review.
(3) Individual deficiencies suspected to be index cases of a general lack in knowledge and skills.	Same approach as in (2). Followup should be conducted by department heads or peer group. Audit may not be sensitive enough.
(4) Periodic review of local clinical experience: complications, deaths, consultative conferences (*eg*, tumor).	Monitor these conferences to provide input for (1), (2), and (3).

The effectiveness of medical education of any type is largely determined by the close match of input and output, by the perception of needs, by the arousal of curiosity and by the timeliness of the topic. The discussion of antibiotic therapy in the relaxing atmosphere of a Carribean cruise may result in less assimilation of transmitted knowledge when contrasted with a meeting which is based on a recent hospital audit or better yet, the critical review of several cases with which the physicians had a direct or indirect clinical relationship. On the other side, meetings away from home may be conducive to better learning because of a more relaxed as well as stimulating atmosphere. Perhaps they should address themselves to questions which are not directly provoked by the clinical experience. They should attempt to assimilate information into knowledge and knowledge into wisdom rather than mechanically transmit one or the other.

Table 4—Job description of the Director of Medical Education

(1) Ultimate responsibility for planning and coordination of all (continuing) medical education. This entails:
   (a) Chairmanship of, or membership in the Medical Education Committee.
   (b) Liaison with audit, utilization, medical records committees, department heads.
   (c) Accountability to Chief of Staff, Executive Committee, and Hospital Administrator.
   (d) Familiarity with intra- and extramural learning resources such as the medical library, audiovisual service and techniques, extramural faculty, and learning centers.
(2) Involvement in nonphysicians' education programs and their coordination, such as educational outreach programs of the hospital, nursing and administrative staff education and patient education.
(3) To assist physicians in the individual planning and documentation of their CME.

Table 5—The function of the Medical Education Committee

(1) To provide channels for communicating needs in medical education ("input").
(2) Collaborative planning of all programs.
(3) Coordination and execution of all programs.
(4) Monitoring of, and feedback from, the programs and participants concerning their quality and effectiveness.
(5) To relate quality and cost control (peer review, PSRO activities, audit studies, utilization control and cost containment) to the education process.

Table 6—The Medical Education Committee (MEC)

Who —	*Does* —	*What?*
(1)	Administrative representation	Control of money, space, and personnel needed for CME.
(2)	Department of Nursing	Coordinate nursing staff education and development with CME.
(3)	Medical librarian, audiovisual service	Make available resources.
(4)	Representatives of all clinical departments	Present intra- and interdepartmental needs for CME.

Physicians perceive as most useful the comprehensive, short course of one to five days duration probably because such a course aims beyond the acquisition of new information at the understanding of new relationships and the development of new physical and intellectual habits. In the same survey, hospital conferences rank lower than self-directed education through the reading of medical literature, not because of their poor potential but probably because of their inadequate planning, structure, and content.[5]

The life span of any recently acquired medical knowledge can be prolonged by the following:

(a) Relevance with regard to a recent clinical experience.
(b) Periodic recycling of the information ("repetitio est mater studiorum").
(c) Dual channels of sensory input: lecture supplemented by slides, supplementary reading assignments, and the like.
(d) Challenging the learner to recall and apply the information by a test.

The ultimate objective of CME should be to improve effectiveness and efficiency of patient care rather than the pursuit of knowledge alone, although this should always be viewed as a means towards the above goal. Greater effectiveness implies that we maximize the achievement of a stated objective; greater efficiency on the other side, means that we accomplish this with a greater output relative to our input of effort, time, cost, and patient discomfort.

Central to a patient's quality of care are not only the knowledge and skills of the physicians but also their attitudes and habits.[6] Of further importance is the structure and functional coordination of the entire healthcare system of which they are a part along with the other healthcare professionals. A good medical education program should be expected to affect all of these components. CME should be conducted on the basis of sound pedagogic principles and with proper organization.[7] Therefore, a realistic model in a community hospital is presented here.

(1) A *Director* or *Coordinator of CME* is appointed. He has to identify the educational needs uncovered by the activities of the committees

concerned with audits, medical records, utilization, and medical education as well as maintain communication with the department heads and other peer groups in the medical staff structure (Table 4). Medical education requires time, space, personnel, and money; and this should be reflected in the Director of Medical Education (DME)'s relationship to the administrative personnel of the hospital. Since CME can hit several targets, not only the medical staff but also the nursing staff and other paraprofessional groups should be represented and involved in the coordination and planning group.

(2) The director or coordinator of CME works with the *Medical Education Committee* (MEC) of the hospital (Tables 5 and 6). He could be the ex officio chairman or place the chairmanship on a rotating basis. The former is usually preferred in order to assure the continuity of planning and committee meetings. Whether he is salaried for this work depends upon the time required, the complexity of the program, and the general feeling of the medical staff about physicians performing administrative work.

The MEC need not include members of the medical records, utilization, surgical tissue, or medical audit committees as long as there is communication with these groups either directly or by periodic review of their minutes. The coordinator or director of medical education should also be a member of the executive committee and maintain close contact with the chief of staff for the joint review of all the planned education programs.

Figure 1 illustrates how central a well organized CME service is to the function of the hospital. The bidirectional arrows imply that input has to be received from, and that feedback should be maintained to other services and committees which control or participate in the healthcare process.

The term "continuing education" wisely states that the acquisition of professional knowledge and skills never lets up. It also implies that education has to be organized on a continuous basis. A schedule of conferences has to be developed which reflects the time cycle of this learning process. Table 7 outlines the periodicity of meetings, their concerns and contents.

The tables and diagrams included in this article summarize function, structure, and relationship of the various components of an effective continuing education system. In a true system these components should be inter-related to achieve a

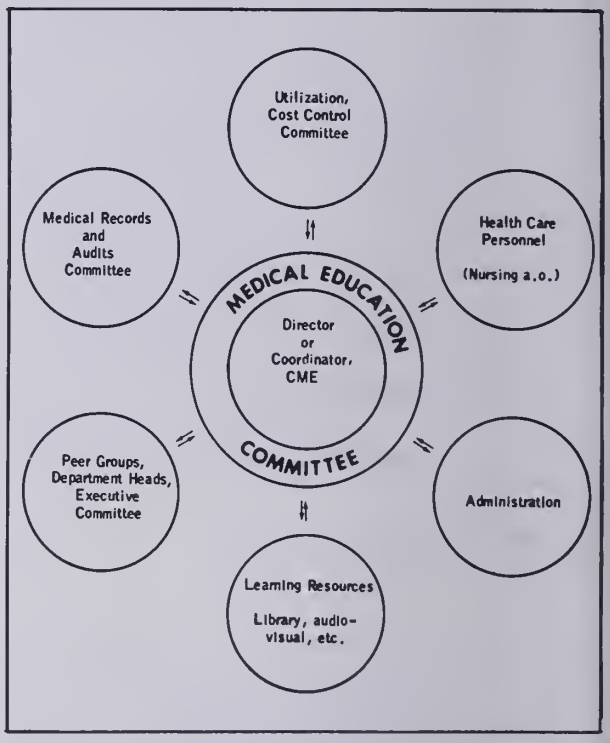

FIGURE 1—The relationship of the Medical Education Committee to the administrative and medical staff structure of a hospital

Table 7—Time schedule of Medical Education Meetings

Program	*Time intervals*	*Contents*
Category I Periodic review of major advances	Monthly - Quarterly - Annual	Cycles of conferences with systematic rotation of surgical, medical, obstetrics-gynecology topics. Examples: "Clinic Days", two to three hour programs with guest speakers.
Category I Institutional problems or deficiencies	Weekly or Monthly	Conferences with presentations of cases, audit results or other institutional studies at their center. A visiting speaker may provide general didactic information on the topic but should address himself to the local problems in particular.
Non-Category I Death review, departmental meetings, specialty conferences	Weekly or Monthly	Review of clinical experiences.

stated objective which, as already stated, should not solely be the enrichment of knowledge but beyond that, improved patient care. The direct relationship of conventional CME to the quality of patient care has been questioned particularly since CME has become mandatory in many states and in several specialty societies. The cost effectiveness of some highly advertised programs also has been doubted. On the other side, integrating CME with the pursuit of improved quality and cost effectiveness of patient care will more readily explain the need for the organizational relationships which are proposed in this article. This will also maintain CME on a more goal-oriented course and reduce the likelihood of ineffectiveness which may ensue when it becomes too diffuse and unrelated to current clinical experience. Greater efficiency of CME can be achieved by intra- or inter-institutional collaboration (Fig 2).

To illustrate the first let us assume a visiting expert is asked to deliver a lecture on disorders of electrolyte metabolism to a hospital staff, such as: "Clinical Aspects of Hypo- and Hyper-natremia." During his stay, he may visit the laboratories and discuss technical problems related to electrolyte and acid-base determinations. Next he reviews with the nursing staff their approach to monitoring of fluid and electrolyte balance in seriously ill patients. The discussion of a hyponatremia audit conducted at this hospital may provide him with interesting insights into the local epidemiology of this problem as well as enable him to spot areas of faulty physician habits. As a result of this experience not only may knowledge and skills be updated but also the organization of diagnostic and therapeutic care. In brief, the whole system may undergo a change for the better.

Interinstitutional collaboration in CME also should be encouraged. Several hospitals can share in the periodic review of major advances or relate to academic centers with which they jointly plan and institute such courses. This sharing process can be cost-saving and have functional advantages particularly if the institutions relate to each other in shared services, in referral or consultation. A medical society or specialty group can also do so, particularly in geographic areas where identical physician groups staff several hospitals. CME programming can also be conducted through cosponsorship of an accredited institution or organization. In that case joint planning and evaluation of the program are required of the collaborating institutions. This approach may be practical for small, rural hospitals which could cooperate in their educational venture with larger referral hospitals or academic centers. The planning and organizing of joined CME systems particularly in rural areas should be facilitated by the State Medical Society of Wisconsin, its Commission on Continuing Medical Education, and by appropriate consultants. In fact, many of the accreditation site visits conducted by this commission have become consultation rather than approbation visits and hopefully helped these institutions develop effective CME programs.

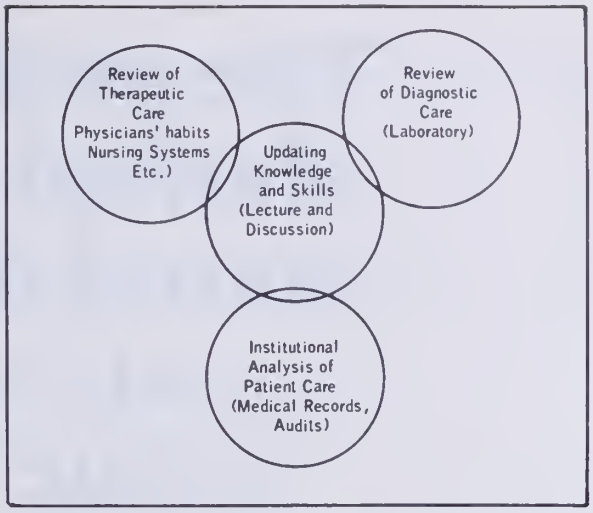

FIGURE 2—How to get the most out of a visiting professor.

Summary

Local CME, which is predominantly hospital-based but at times also conducted by local physician groups, has become the most effective as well as unifying pathway in the control of quality and cost of healthcare. Therefore, it requires the precise identification of its function and objectives and the establishment of an appropriate organizational structure. If properly carried out, it should convert a loosely associated physician staff into a well-coordinated and collaborative group.

Such a healthcare system should be able to deliver medical care of high quality and cost efficiency through the intermediary process of constant learning and insight formation and eliminate the need for a more authoritarian system which would rely mainly on central control and disciplinary action to enforce its standard of care.

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FWT

Scientific Medicine

REFER TO—Brahos GJ, Mueller G: Late colonic stenosis secondary to seat belt injury. *Wisconsin Med J* 79:29-31 (Feb) 1980

KEY WORDS—Late colonic stenosis, seat belt trauma

Late colonic stenosis secondary to seat belt injury

George J Brahos, MD and **Gustave Mueller, MD**
Madison, Wisconsin

• *The right colon appears relatively protected from delayed sequelae of blunt abdominal trauma. This report describes a case of late right colonic stenosis secondary to seat belt injury, its pathophysiology, and successful surgical management by right hemicolectomy.*

In recent years the use of seat belts has dramatically reduced the occurrence of fatal motor vehicle accidents.[1,2] Although these devices appear to lessen the severity of many types of trauma, there has emerged an entirely new spectrum of injuries among wearers, both secondary to the belts themselves[3] and because many more victims survive long enough to receive medical attention.[4]

Compared to other visceral damage, such injuries to the colon are not often seen, and failure to recognize them has sometimes been associated with delayed sequelae. The following is an instance of late right colonic stenosis, which to our knowledge has not been previously described secondary to seat belt injury.

CASE REPORT. A previously healthy 26-year-old man was the driver of a jeep involved in a roll-over accident in May 1977. He was found at the scene, unconscious, and suspended upside down in the driver's seat by his lap-type seat belt. Upon arrival at Madison General Hospital 45 minutes later, he was in profound shock, with a pulse of 150 per minute, blood pressure of 80/0 mm Hg, and respiration of 14 per minute. The pupils were fixed and dilated, and he responded only to painful stimuli. There were several facial lacerations, decreased breath sounds bilaterally, and abrasions of the lower abdomen in a bandlike transverse distribution. A chest x-ray film showed bilateral pneumothoraces. Catheterization of the bladder yielded clear urine, and peritoneal lavage was negative for blood. Arterial blood gases drawn just prior to intubation revealed pH 7.09, pCO_2 54, and pO_2 26, but these values rapidly returned to normal after administration of sodium bicarbonate, institution of mechanical ventilation, and placement of bilateral chest tubes. The patient did remarkably well, progressively became more alert, and was extubated on the third day. While in the hospital he complained on several occasions of lower abdominal discomfort, but he continued to eat regular meals and have normal bowel movements. Serial abdominal examinations remained negative, except for some discomfort over the cutaneous abrasions. He was discharged ten days after injury with no apparent problems, except for residual decreased visual acuity in the left eye.

He was completely free of abdominal pain for the next several weeks, but then he began to notice postprandial cramping in the periumbilical region and right lower quadrant, with relief obtained by sudden passage of flatus. These symptoms progressed; and by the time of readmission to the hospital two months later, he also had developed frequent loose

From the Department of Surgery, University of Wisconsin Clinical Science Center and Madison General Hospital, Madison, Wisconsin. Reprint requests to: George J Brahos, MD, Dept of Surgery, Clinical Sciences Center, 600 Highland Ave, Madison, Wis 53792 (Phone: 608/263-5214). Copyright 1980 by the State Medical Society of Wisconsin.

Figure 1

stools and had sustained a 25-lb weight loss. Physical examination was unremarkable, but barium enema revealed a long stenotic area in the ascending colon (Fig 1).

After the appropriate bowel preparation, laparotomy was performed seven weeks after the injury using a transverse incision. The stenotic region of the ascending colon was densely scarred, with dilatation of the cecum proximal to this point. Arterial pulsations in the mesentery were good. Except for a few filmy adhesions, no other intraabdominal pathology was found. A right hemicolectomy was performed without complication, with continuity reestablished by ileoascending colon anastomosis. The patient had an uneventful recovery. He is now well and without symptoms.

Pathologic examination of the specimen revealed a 14-cm long stenosis, with a lumen of only a few millimeters at its narrowest portion. The mucosa was intact, but there was dense fibrosis of all other layers, areas of old hemorrhage, and a few inflammatory cells (Fig 2).

DISCUSSION. Among abdominal visceral injuries secondary to seat belts, those involving the colon are relatively uncommon.[3,5,6] Mechanism of damage has been attributed to various combinations of shearing forces due to compression, rupture by excessive pressure, and shearing related to fixation of the bowel by ligaments or mesenteries.[6] Many of these injuries are suggested by physical examination or diagnostic peritoneal tap or lavage, while others are discovered unexpectedly at the time of laparotomy for other trauma. In these instances successful definitive management can be undertaken. Unnecessary delay of operation beyond several hours, on the other hand, has resulted in a marked increase in morbidity and mortality.[3] Regardless of whether an operation is performed, if the blunt colon injury is not recognized and the patient survives, late sequelae have been known to occur.

The pathophysiology of late colonic stenosis secondary to blunt trauma has been variously at-

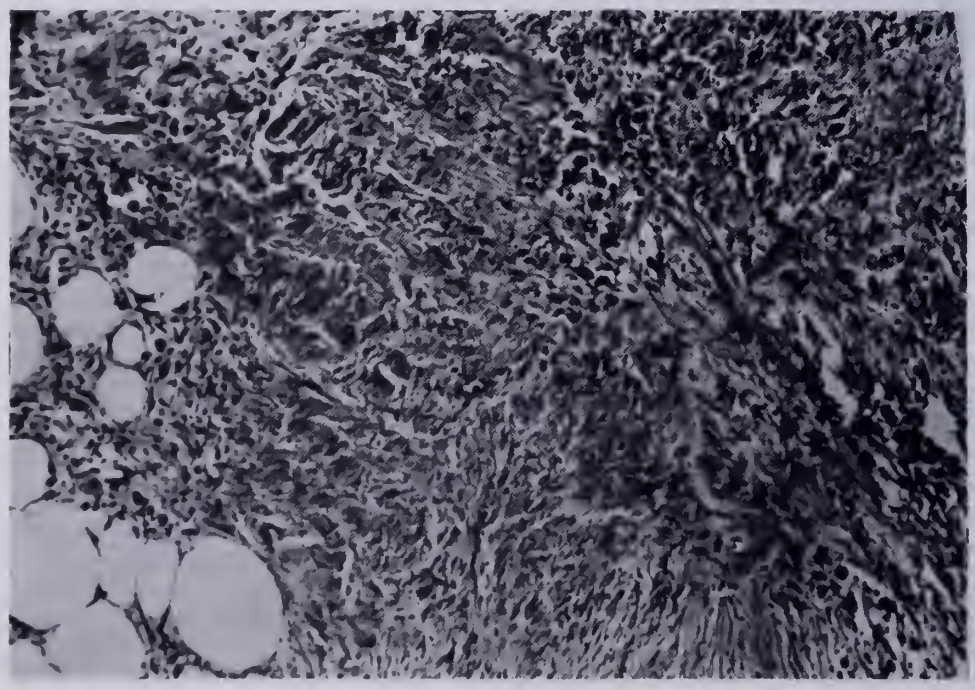

Figure 2

tributed to a combination of infection, vascular damage, or hemorrhage and hematoma. Mays and Noer[7] reported a case of stenosis of the descending colon resected eight months after blunt trauma, with dense fibrosis found in the specimen. However, these authors were unable to reproduce cicatricial stenosis by blunt trauma in rabbits, and they postulated that a state of "subnecrotizing ischemia" may be necessary for late changes to occur. Altner,[8] in his report of two cases of late stenosis secondary to blunt trauma, both of which were in the left colon, stated that extensive interstitial damage is a necessary mechanism, with destruction of either mucosa or submucosa; and he suggested concomitant vascular injury as a contributing factor. A vascular etiology is applicable to our case as well, for in addition to the forceful blunt trauma which probably occurred initially, the patient was suspended by the restraining seat belt while in a severely hypotensive, hypoxic, and acidotic state. Even though the mesenteric circulation appeared to be intact at the time of operation, it is possible that intramural small vessel arterial and venous injury had occurred, resulting in late fibrosis due to chronic ischemia.

Although late stenosis of the colon due to blunt trauma is unusual, specific involvement of the right side is rare. In their review of the literature Mays and Noer[7] collected just ten such cases of cicatricial stenosis due to blunt injury, but only two involved the right colon, and neither of these were related to seat belts. Due to its relative mobility, the sigmoid would appear protected from blunt trauma because of its tendency to slide away during impact. However, its mobility may in fact predispose it to crushing against the lumbosacral spine, and therefore may be responsible for the preponderance of injuries on the left. The left colon also may be more vulnerable due to an inadequate marginal artery.[7] The relatively immobile right colon, on the other hand, seems well-protected from blunt trauma due to its location in the right gutter and apparently good blood supply.

Although the present case appears to be a rare occurrence, similar types of injury would be expected in the future, concomitant with man's continued fascination with high-speed acceleration. Awareness of mechanisms of injury, their location, and late sequelae is mandatory for all physicians involved in the care of these patients.

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Abstracts

Axillo-axillary bypass for subclavian steal syndrome

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Since 1972, 14 patients with subclavian steal and four with primary vascular insufficiency of the arm have been operated on using the axillo-axillary bypass graft. Two grafts have been replaced, one after nine months for threatened erosion, and the other after three years for thrombosis due to disease progression in the donor artery. The new grafts were patent at three and at 2½ years. One graft was occluded at six months and was not replaced. All other patients under observation in 1978 have grafts patent at one month to 6½ years (average 2.2 years). Life table analysis shows the probability of graft patency (20 grafts) is 76% at three years. In the subclavian steal group steal on the left side predominated 2:1. Cerebral symptoms predominated with arm symptoms less often seen, although six patients had both. Associated vascular disease and hypertension were common. There was no mortality and few complications. Axillo-axillary bypass grafting is considered the operation of choice for patients with subclavian steal syndrome. (Read before the 86th annual meeting of the Western Surgical Association, Scottsdale, Ariz, Nov 15, 1978.)■

REFER TO—Boland TW, Agger WA: Cutaneous larva migrans—recent experience in the La Crosse area. *Wisconsin Med J* 79:32-34 (Feb) 1980

KEY WORDS—Cutaneous larva migrans, skin eruptions

Cutaneous larva migrans

Recent experience in the La Crosse area

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Cutaneous larva migrans is a skin eruption produced by the aimless meandering of the dog or cat hookworm larvae through the epidermis of man. As with other helminthic dermatoses, the localized allergic response to this foreign invader produces a severe inflammatory reaction within the epidermis associated with marked pruritis. Small papules, vesicles, and pustules develop within hours to several days after the larvae penetrate the epidermis. These often become excoriated and secondarily infected. As larvae begin to migrate through the epidermis, they form serpiginous, raised tunnels which advance by several millimeters per day.[1] Although the diagnosis is relatively easy to make in an endemic area by observing these characteristic epidermal tunnels on exposed individuals, it is more difficult in northern regions of the United States where these hookworm larvae are infrequently found. The following three cases illustrate our recent experience with this unusual parasitic infection in the La Crosse, Wisconsin area.

CASE REPORTS. ***Cases 1 and 2:*** A 66-year-old white male was seen on August 18, 1978 with complaints of a swollen, markedly pruritic right foot of one week duration. He had initially noted small, reddish papules on the sole of his foot; these gradually spread to the dorsum over several days.

On examination, the right foot was diffusely edematous with increased warmth and erythema extending up to a sharply demarcated border at the ankle. Closely spaced, 5-7 mm, excoriated papules covered the entire foot. The plantar surface was more severely involved with areas of weeping and crusting. The interdigital spaces were markedly macerated.

He was treated for a presumed contact allergic dermatitis and secondary bacterial cellulitis with soaks, dexamethasone spray, and oral penicillin. One week later the cellulitis had resolved, but more numerous excoriated papules with crusting were noted. The patient's wife accompanied him and indicated that her left foot had also erupted with similar lesions during the preceding two days. Inspection of her foot revealed a few erythematous papules and turbid vesicles, primarily located over the dorsum and in the interdigital web spaces. To control their intense pruritis, a short course of systemic steroids and antihistamines was begun.

When they returned two weeks later there was no significant improvement. Despite the very marked eczematoid reaction involving the husband's foot, close inspection revealed several discrete, serpiginous burrows over the plantar surface (Fig 1). Similar, slightly elevated burrows were also present over the instep and dorsal surface of the wife's foot (Fig 2). Skin scrapings from several burrows failed to demonstrate any parasites or eggs. A leukocyte and eosinophil count in the husband and wife respectively revealed the following: white blood cell counts of 15,600 per cu mm (37% eosinophils) and 13,400 per cu mm (21% eosinophils).

Cutaneous larva migrans was diagnosed, and the patients were queried regarding possible exposure to infected animals. A neighbor had recently brought a puppy home from southern Illinois. This animal frequently deposited stools in their yard, and both patients habitually walked about the yard barefooted. Stool samples subsequently obtained from the puppy revealed typical hookworm ova (Fig 3).

Following a course of 100 mg of mebendazole twice daily for three days, the wife's lesions rapidly resolved. The husband's foot was initially only slightly improved with this therapy. Further treatment with 25 mg per kg of thiabendazole twice daily for two days resulted in complete clearing.

Case 3: A 16-year-old male was seen for a routine summer camp physical; he complained of a rash on his left foot which had been present for two weeks. On examination there was an erythematous, excoriated lesion which extended from the plantar surface, between the first and second toes, and over the dorsum for a distance of 5 cm. There were several serpiginous tunnels adjacent to the longer lesion. Microscopic examination of scrapings from these tunnels disclosed a single filariform larva. A blood cell count revealed a 13% eosinophilia. When the

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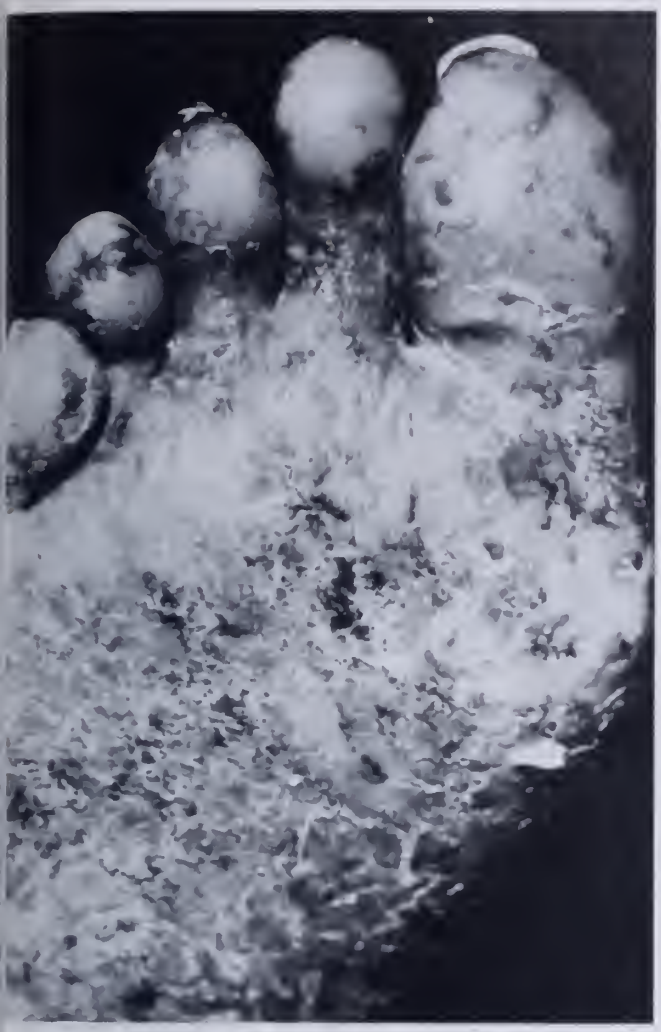

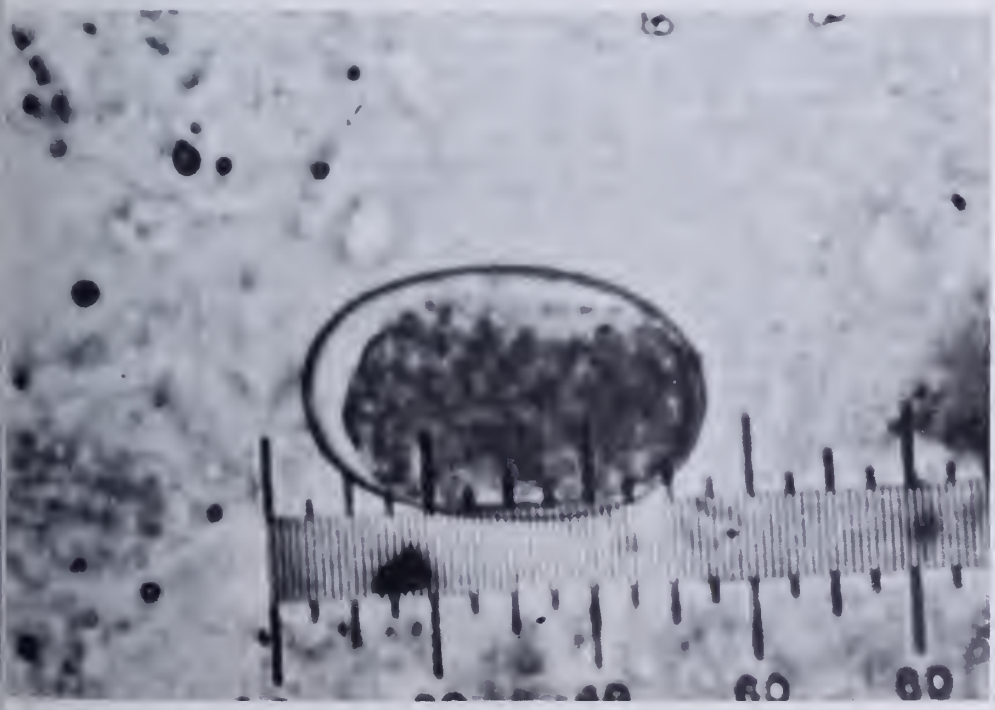

Figure 1—Thin, serpiginous burrows measuring 10-15 mm are present over the third and fourth toe pads. A broader, pustular burrow is present over the first toe pad.

Figure 2—Slightly elevated burrow 4 cm in length over dorsum of wife's foot.

Figure 3—Hookworm ova isolated from dog feces.

patient was asked about exposure to pets, he recalled having walked about his backyard barefoot on several occasions to retrieve his dog. He was treated with topical steroids and 25 mg per kg of thiabendazole twice daily for two days but has not been seen in followup.

DISCUSSION. Although the dog and cat hookworm, *Ancylostoma braziliense,* is the most common cause of cutaneous larva migrans ("creeping eruption"), other nematodes also have been incriminated. These include *Ancylostoma caninum, Uncinaria stenocephala, Necator americanus,* and *Strongyloides stercoralis.*[2] *Ancylostoma braziliense* is endemic to the southeastern United States, but it also is found somewhat less commonly along the coasts of Texas, Mexico, and Central America. Areas of South America are hotbeds of infection. Maturation of the larva requires a warm, moist, sandy soil which is commonly found in these regions. Since the larva is killed by freezing, only sporadic cases of human cutaneous infection are reported in the northern regions of the United States.[3]

The adult worm lives in the small intestine of the cat and dog. Eggs are passed through the stool and into the soil where rhabditiform larvae develop and grow. These larvae later transform into the infective filariform larvae. When these larvae come in contact with human skin, they readily penetrate and begin burrowing within the epidermis. This incites a local inflammatory response with a predominantly eosinophilic and lymphocytic infiltrate. Since man is not the natural host of *Ancylostoma braziliense,* the larva is unable to penetrate beneath the stratum germinativum and, therefore, is unable to complete its life cycle. Instead, the larvae are confined to the epidermis where they produce pruritic, slightly elevated, erythematous to violaceous, serpentine tunnels. As the larva advances, the uninhabited end of the tunnel becomes crusted. Occasionally larvae may break through the stratum germinativum, enter a blood vessel, and circulate to the lung where they produce transient pulmonary infiltrates. This is usually a self-limited infection lasting only several months without treatment.[4]

The diagnosis of cutaneous larva migrans is not difficult if the typical skin lesions are recognized on an individual who has a peripheral eosinophilia and a history of contact with possibly infected soil. Recovery of the larva by either skin biopsy or scraping should not be required before instituting treatment because the parasite is difficult to find by these methods. Since the larva does not complete its life cycle in man, a stool examination from the infected individual would not be expected to yield positive results. However, fresh stool specimens from suspected animal vectors are useful: a positive stool for hookworm ova helps to substantiate the diagnosis in less typical cases and can also be used to identify infected animals for concurrent treatment with antihelminthic drugs.

The present recommended therapy is 25 mg per kg of thiabendazole twice daily for two days. If only a few lesions are present, local treatment with liquid nitrogen or ethyl chloride spray is acceptable.[5] Antihistamines and topical steroids may be used to control the associated pruritis.

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Abstracts

Control of colonization and transmission of pathogenic bacteria in the hospital

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A hospital is a milieu conducive to the development and spread of infection. Patients' own flora, microorganisms in the hospital environment or those carried by medical personnel, intrinsically contaminated commercial products, and infected patients are major reservoirs of nosocomial pathogens. Use of invasive devices greatly amplifies transmission, colonization, and susceptibility to infection. *Staphylococcus aureus* infections are caused by autochthonous strains or exposure to medical personnel who are carriers; infections with gram-negative bacilli are endogenously acquired or derive from contact with contaminated aqueous sources within the hospital. Carriage of microorganisms on the hands of noncolonized medical personnel appears to be a major mode of cross-infection. Research is needed to better define the epidemiology of endemic nosocomial infections in order to develop more effective control measures, to evaluate more widely the efficacy of protective isolation, and to improve the safety of devices. More consistent application of infection control measures would have considerable immediate benefit. ■

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KEY WORDS: Esophageal cancer, squamous cell carcinoma, cobalt therapy

Cancer of the esophagus: five-year local experience

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•Reported results do not seem to bear out the increasing trend toward surgical aggressiveness in treating esophageal cancer. A review of our experience between 1971 and 1976 with 84 patients with esophageal cancers is presented. Results with squamous cell carcinomas paralleled Doctor Pearson's experience and confirms our current philosophy that in most cases, squamous cell carcinoma of the esophagus is a non-surgical disease. Long-term survival and palliation were better with cobalt therapy than with surgical resection. In addition, there were no deaths directly related to the cobalt therapy.

IN REVIEWING literature on the subject of the treatment for esophageal carcinoma, one cannot help but agree with the comments made by Parker[1] and Ellis.[2] There truly are no controlled studies comparing radiation with surgery. The techniques of radiation and of surgery reported from different centers vary so widely that worthwhile comparisons are difficult to make. In spite of this, the trend in therapy appears to be toward a more aggressive surgical attack on this disease.

Several recent surgical series[3,4,5] report resectability rates of as high as 80 percent of patients in the series and five-year survival rates after resection of 14 percent. One of the most impressive surgical series, but one questioned by many in this country, is the report from the Peoples Republic of China[6] in which resection was accomplished in 77 percent of the patients in the series with a five-year survival rate of 26 percent. Ellis,[2] an advocate of surgery, has stated that he has achieved a resectability rate of 84 percent with a 2.2 percent surgical mortality. However, no long-term survival data were given. In an earlier paper,[7] he quotes a 55 percent five-year survival rate for squamous cell carcinoma of the cardia, a figure taken from the large series of Gunnlaugsson reported in 1970.[8]

Parker,[1,9] also an advocate of resection, but in combination with preoperative irradiation, reports a 19 percent five-year survival rate with the combined approach. He also reports 31 percent surgical mortality.[1] Of considerable interest is that in his later report[1] he commented he had never had a five-year survivor with squamous cell carcinoma of the lower thoracic esophagus. This contrasts rather starkly with the very optimistic data for the same tumor and location reported by Ellis from Gunnlaugsson.[7,8]

To finally further confuse the issue is Pearson's series[10] in which he reports five-year survival for squamous cell carcinomas of the esophagus treated with radiotherapy alone to be better, overall, than with surgery, regardless of location of the tumor in the esophagus.

In light of these conflicting data in the literature, comments by Cukingham and Carey in their collective review of cancer of the esophagus seem appropos.[11] "Since only a few patients are cured of this disease, more surgeons have come to accept palliation as the major goal of treatment." At present, "Three methods of palliation are available and individual preferences and statistics generally dictate the type of treatment instituted."

Since 1970, we preferentially referred squamous cell carcinomas of the esophagus for irradiation. We had utilized the preoperative cobalt program of Nakayama prior to 1970, but abandoned it when we could not duplicate his data. We have not utilized the combined approach described by Parker.[10]

Whatever preference one has in regard to his choice of treatment, it is certainly true that it must offer his patients results that are at least as good as the competing alternatives; or he should consider changing his preference. Since we have moved in the opposite direction to the present prevailing trend of our surgical confreres, a review of the results of our preference, since its adoption, seemed timely.

Paper presented by Doctor O'Connor before the Wisconsin Surgical Society, April 15, 1978, Milwaukee, Wisconsin. Publication support provided. Reprint requests to: Thomas M O'Connor, MD, Dept of Surgery, St Luke's Hospital, 2900 West Oklahoma Ave, Milwaukee, Wis 53215. Copyright 1980 by the State Medical Society of Wisconsin.

Method. The records of all patients seen in our office between 1971 and 1976, with the diagnosis of esophageal carcinoma, were reviewed. The series consisted of 84 patients about equally divided between three institutions in which we practice.

Results. Analysis of the patients in the series (Table 1) indicates that it is comprised of the usual cross-section of patients with esophageal carcinoma.

Three patients refused any form of therapy.

Eighteen patients in the series were operated on and 14 of these had resection completed. There was one surgical death and there were two major surgical complications in the resected patients. Traditionally, the rate of operability is usually reported to be about 40 percent of patients presenting with cancer of the esophagus.[12]

Table 2 lists our relative and absolute contraindications for surgical resection. Those listed as relative are, in themselves, not sufficient for us to interdict surgical treatment; but if two or more are present, we refer the patient for nonoperative therapy.

We had included the diagnosis of squamous cell carcinoma on our list of contraindications as a result of two monumental articles in the literature dealing with squamous cell carcinoma. Lattis, et al[5] concluded that the prognosis of squamous cell carcinoma of the esophagus was unrelated to the location of the tumor in the esophagus or to its degree of cellular anaplasia. Pearson,[10,13] (Table 3) had shown that the result of treatment in a group of 1593 patients with squamous cell carcinoma was better with radical cobalt therapy than it was with resection of the tumor, regardless of what level the tumor was located at in the esophagus. There were no deaths in Pearson's series that were directly related to the cobalt therapy, a finding also mentioned by Parker in his report.[9] For a more accurate appraisal of results, we divided the patients according to their tissue diagnosis. Adenocarcinoma, by many, is considered to be a tumor arising in the stomach and extending into the esophagus, rather than a true esophageal cancer.

Table 4 summarizes the results of treatment, in our series, of 64 patients with squamous cell carcinoma. None of six patients in whom resection was completed lived longer than 15 months; their average survival following resection was five months. All of these were lower third esophageal lesions, felt to represent potentially curable lesions. Of the 57 patients who were referred for cobalt therapy, two are free of disease over two years from the date of completion of their treatment. Average survival for the remaining 55 patients treated with cobalt was six months from the date of initiation of treatment. Our smaller experience confirms Pearson's observation of a better long-term prognosis with cobalt therapy for squamous cell carcinoma.

Adenocarcinoma involving the esophagus is an entirely different disease. This tumor is radioresistant and, therefore, resection (where possible) was the treatment of choice. Table 5 is the analysis of our 17 patients with adenocarcinoma. Eight had resection completed; three of these are presently disease-free over two years from the date of resection. The remaining five resected patients — despite the fact

Table 1—Analysis of 84 patients with esophageal carcinoma

Age (yr)	*Sex*	*Cell Type*	*Tumor Site in Esophagus*		
33-93	Male - 65 Female - 19	AdenoCa - 18 Sq Ca - 76	Upper 1/3 Mid 1/3 Distal 1/3	19 31 33	(all Sq Ca) (3 AdenoCa) (14 AdenoCa)

Patients equally divided between three hospitals

Table 2—Contraindications for surgical resection

Relative	*Absolute*
Tumor fixed at endoscopy	Tumor located in cervical esophagus
Age of 70	Metastasis
Tumor length > than 5 cm	Medical contraindications to major surgery
Tissue diagnosis of squamous cell carcinoma	

Table 3—Treatment results: cobalt -vs- resection

Tumor location	*Overall cobalt 21%*	*Overall resection 11%*
Upper 1/3	29%	14%
Mid 1/3	19%	8%
Distal 1/3	15%	11%

Table 4—Treatment results in 64 patients with squamous cell carcinoma

	Resection-6 Pts	*Cobalt-57 Pts*
Long-term survivors (over 2 years)	0	2
Deaths related to treatment	1	0
Average survival after treatment	5 mos	6 mos

One patient died prior to any treatment being started

that in three, gross disease was left behind at the time of resection — survived, symptom-free, an average of seven months from their surgery. The nine patients for whom resection was not done did receive cobalt therapy; referral for this was not made by our office. In addition, two had adjuvant chemotherapy as part of their treatment program. None of these nine patients lived longer than five months.

Discussion. With usual surgical indications, present techniques, and anesthesia, mortality for resection of the esophagus should not be in excess of 11 percent.[14] But one can justify increased mortality if overall five-year survival is improved. Several recent surgical series suggest this is so.[3,4,9,14]

Table 6 is a summary of the average operability, resectability, and five-year survival data from four series[3,4,9,14] reporting and advocating extending surgical indications to greater numbers of patients. The overall five-year survival rate, when these percentages are converted into concrete patient numbers, is 7 percent. The increased survival data reported is misleading, since it refers to the select group in these series of patients who have survived surgery. Thus, it seems to us that the advocates of extending surgery for patients with cancer of the esophagus have not made a very strong case, since overall five-year survival rates have not been changed from that reported in standard textbooks of surgery.[12] Yet, a larger number of patients has died as a direct result of the treatment prescribed.

However, quality of life, afforded by treatment efforts — even though recognized as palliative — for any disease, is an important consideration. For carcinoma of the esophagus it is, perhaps, the paramount concern, since, unfortunately, palliation is the best treatment the physician can offer to the majority of his patients with cancer of the esophagus, the point made by Cukingham and Carey in their collective review.[11]

Several authors[3,12,15] indicate that nearly all patients who have resection completed enjoy a better quality of life, as measured by relief of their dysphagia, for a longer period (average of 11 months) than the unresected patients or the patient treated with radiation therapy alone. To place those comments in better perspective for comparison, we again considered it necessary to separate the patients in our series according to tissue diagnosis, since our philosophy of treatment varied depending upon whether a patient had adenocarcinoma or squamous cell carcinoma.

Table 7 is a comparison of the palliative results of relief from dysphagia, in the nine patients with adenocarcinoma in our series for whom surgery was not considered, with the five patients for whom resection was completed. The total palliative failure in the unresected patients raises the question, "Should we have increased surgical aggressiveness in unresected patients?" They were considered inoperable because of liver metastasis. Stone[14] reports that patients with adenocarcinomas of the esophagus and liver metastasis rarely survive more than five months. Our experience confirms that observation. Brown[16] has recently written on the questionable value of extensive palliative surgery in patients with

Table 5—Analysis of 17 patients with adenocarcinoma

	Resection-8 Pts	*Nonoperated-9 Pts* (x-ray & chemotherapy)
Long-term survivors (over 2 years)	3	0
Average survival after treatment	7.5 mos	< 5 mos

Table 6—Analysis of unselected group of 100 patients with carcinoma of esophagus

	Patients potentially cured
90% Operability	90
80% Resectability	72
26% Mortality with resection	50
14% Five-year survival after surgery	7

Overall five-year survival rate = 7%

Table 7—Results of palliation in adenocarcinoma

Completed resection - 5		*X-ray & chemotherapy - 9*
Relief of symptoms	5	0
Survival from treatment	7.5 mos	5 mos
Liver metastasis	0	9

Table 8—Comparative results of palliation in squamous cell carcinoma

	Resection	*Cobalt*	
	Total 6 pts	*Palliative 4500 r Total 38 pts*	*Curative 6000-6500 r Total 19 pts*
Freedom from symptoms	4	22	19
Palliative failures	2	16	0
Deaths related to treatment	1	0	0

incurable intraabdominal carcinomas and suggests it is unjustified if expected survival following surgery is less than five months. Total average pre- and postoperative hospital stay, for extensive resection of the esophagus, is approximately one month. The terminal phase of a patient's disease, which also requires hospitalization, is approximately two weeks. Therefore, for the less than four month out-of-hospital palliation potentially achievable in these patients, we also find it difficult to justify increased mortality and morbidity associated with extensive resections of the esophagus.

Table 8 is the analysis of the results of treatment for the patients with squamous cell carcinomas. Those treated with x-ray therapy are further divided according to whether they received curative or palliative cobalt therapy. The type of cobalt therapy was determined by the therapy consultant on the basis of his interpretation of the status of the patient and his disease. It can be seen that the majority of patients, 38 of 57, were considered to have disease that warranted palliative cobalt therapy only; they received less than 4500 rads. Nineteen received curative cobalt therapy as defined by Pearson.[10] The fact that the patients in the palliative x-ray group survived an average of less than four months indicates the advanced stage of their disease. In 19 patients who received curative cobalt therapy, two patients are surviving disease-free over two years. Average survival of the other 17 patients was seven and one-half months. All of the patients in the curative x-ray group were completely relieved of their symptoms of obstruction. The symptom-free period for these 17 patients is slightly longer than the five-month, symptom-free survival of the six patients who had resection completed. None of the 17 patients died as a direct result of their cobalt therapy, whereas one patient in the group of six operated on died as a direct result of his surgical resection.

Relief of dysphagia for all but 16 of 57 patients treated with cobalt is somewhat less than the 90 percent success rate for surgery quoted by Ellis, but much higher than the 20 percent for radiation alone quoted in the same article.[17] However, it should be noted again that among the group of 19 patients treated with curative cobalt irradiation among whom surgical candidates could be expected to be found, all were free of dysphagia after completion of therapy. It would be this irradiated group that is compared to those surviving surgical resection and for whom the 90 percent successful palliation is reported.

Ellis[17] and Belsey[3] report the symptom-free survival period after resection to be 11 months. If we exclude the two long-term survivors, the symptom-free period in the 17 remaining patients, following initiation of curative cobalt therapy, was seven and one-half months. It must be emphasized again that cobalt therapy, in our experience as well as that of Pearson[10] and that of Parker,[1] had not resulted directly in the death of any patient so treated. Further, it should also be pointed out that Belsey's survival data is measured from the start of the patient's symptoms. It is known that there is an average three-month delay between the patient's first symptom and the establishment of a tissue diagnosis with subsequent start of therapy. Thus, at least in Belsey's series, if one subtracts this delay from the survival, corrected survival of eight months from treatment to demise is obtained. In most surgical series, there is an increased mortality rate above the 10 percent commented upon by Stone[14] associated with the extension of surgical indications with what seems to us to be very little improvement in palliative survival time.

Cukingham and Carey note, in their collective review,[11] that there is about a seven and one-half month survival after surgery which is, of course, comparable to the seven and one-half month survival in the 17 patients in our series who received curative cobalt therapy. For the same degree of palliation, for the same period of time, and for no change in the overall five-year survival rate, it is difficult for us to justify the increased surgical mortality with which an increased surgical aggressiveness for squamous cell carcinoma of the esophagus is associated.

Though we have not utilized the combined approach described by Parker, the results he reports[1,18] are not encouraging enough yet to make us change our present approach; in fact, they seem to be supportive of it. In reviewing his results, he has divided the cases into those he considered inoperable and those he considered operable. Among the inoperable group of patients who received radiation therapy only, he had a five-year survival rate for six patients, or 8 percent of the total.[1] With the combined approach and a variety of different methods of resection, he had a total five-year survival rate for six patients, or 8 percent of this group. With surgery, he reports a 31 percent mortality rate and with radiotherapy alone, none related to the x-ray therapy. As with the surgery alone, the end result of the combined approach as far as improved five-year survival, would not appear to offer enough benefit to justify the increased mortality. Palliation and time of symptom-free survival appear to be, at best, marginally better. The patients who survived surgery, but who were not long-term survivors, lived about the same number of months as those who had irradiation alone; and the irradiated patients represented the poorer risk patients. For the patients who died after surgery, one cannot certainly claim any palliative benefit. In fact, we

would suggest the possibility that among these patients, the best candidates for treatment similar to our 19 ideal treatment candidates treated with curative cobalt, there might be several who would have been long-term survivors if they had received radiotherapy only. For the others, the majority, if we can apply our own results, would have had about seven to eight months of symptom-free palliative survival.

Conclusion. Up to the present, there does not appear to be any concrete evidence suggesting that any of the present methods of treatment for carcinoma of the esophagus have, in reality, altered favorably the five-year survival rates in unselected groups of patients.

Even in selected series of patients, five-year survival rates seem controversial and certainly leave many questions unanswered concerning the benefits of the trend toward increasing surgical aggressiveness with its increased surgical mortality and morbidity. Palliation continues to be the best we have to offer to most of these patients. Since that is the case, it behooves each surgeon to critically review his preferred method of palliation and compare it with the experience of others so he offers the best palliation to the most patients.

Our experience seems to bear out Pearson's results; and although we run the risk of being called defeatists by our surgical confreres who advocate extending surgical indications to more patients, we will continue to preferably refer patients with squamous cell carcinoma of the esophagus for cobalt therapy until surgical data can unequivocally match the competing alternative. We feel they do not presently do so.

For patients with adenocarcinoma involving the esophagus, resection, whenever possible, seems unquestionably the treatment of choice.

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Abstracts

A study of antimicrobial misuse in a university hospital

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We undertook a prospective study to determine patterns and sequelae of antimicrobial misuse and factors associated with inappropriate antimicrobial therapy in a teaching hospital. Over an eight-week period, 144 (26.2%) of 549 hospitalized medical and surgical patients received one or more courses of antimicrobial therapy. An average course comprised 1.4 drugs. Presumptive infection was the reason for 70% of courses and prophylaxis, 30%. Therapy was judged appropriate in 59% of courses overall. Unnecessary therapy, poor drug choice (bacteriologically, pharmacologically, or both), or misguided prophylaxis most frequently underlay inappropriate therapy. Adverse reactions (17% overall) were twice as frequent and the cost of therapy was 55% greater in inappropriate courses. Performance of pretherapy cultures ($p<0.05$), obtaining gram-stained smears of sputum in presumed respiratory tract infections ($p<0.001$), and notation in the record that antimicrobial therapy had been instituted ($p<0.001$) were strongly associated with appropriate therapy. This study underscores the need for more effective programs of postgraduate education which stress basic principles of infectious disease and antimicrobial pharmacology and guidelines for prophylaxis. Antimicrobial utilization review should figure heavily in hospital programs of medical self-evaluation. Additional measures to upgrade the use of antibiotics are discussed. ■

REFER TO: DeAngelis C, Sargent J, Chun MK: Breast milk jaundice. *Wisconsin Med J* 79:40-42 (Feb) 1980

KEY WORDS: Jaundice, breast milk, hyperbilirubinemia

Breast milk jaundice

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● *Fifty-three (25.7%) of 206 breast milk fed (BMF) infants developed serum bilirubin levels over 10 mg per dl compared to 4 (8.9%) of 45 formula fed (FF) infants ($p<0.01$). Forty-one (19.9%) of the 206 BMF infants had bilirubin levels over 12 mg per dl compared to 3 (6.7%) of the 45 FF infants ($p<0.03$). One (2.2%) of the 45 FF infants compared to 14 (6.8%) of the 206 BMF infants received phototherapy.*

Bilirubin levels peaked at day 4.0 in FF infants (range 2 to 6 days) compared to day 5.6 in BMF infants (range 3 to 10 days). One (2.2%) FF infant had hyperbilirubinemia (>10 mg per dl) up to day 10 while 13 (6.3%) BMF infants had hyperbilirubinemia more than 10 days.

There was a definite preponderance of hyperbilirubinemia during the fall and winter months, and this phenomenon appeared to be related to the average number of sunshine hours per month.

In 1963, several investigators described prolonged hyperbilirubinemia in breast milk fed infants.[1,2] In 1964 Arias, et al reported prolonged unconjugated hyperbilirubinemia associated with breast feeding, and they identified a steroid, pregnane-3 alpha, 20 beta-diol, in maternal milk that inhibited glucuronide formation in vitro.[3] Since that time, there has been considerable doubt that this steroid was responsible for the phenomenon.[4-9]

More recent studies have suggested that the breast milk "inhibitors" are related to abnormally elevated lipase activity in the milk and that these breast milks develop abnormally elevated concentrations of free fatty acids when stored at 4° C.[10] It has been further identified that addition of free fatty acids to noninhibitory breast milk can make it inhibitory of glucuronyl transferase. It is not clear, however, that the free fatty acids are responsible for the breast milk jaundice because the milks, when analyzed fresh, were not inhibitory.[11]

It is currently recognized that breast milk jaundice does exist. Some infants who are being breast fed exhibit prolonged neonatal hyperbilirubinemia that is associated with unconjugated bilirubin concentrations of the serum that exceed 10 mg per dl and can persist for months.[6,12-14] The purpose of this paper is to report the results of a retrospective study on hyperbilirubinemia in 251 newborn infants from a clinical practice with an unusually high incidence of breast milk feeding mothers.

PATIENTS AND METHODS. The Ambulatory Pediatric Services of the University of Wisconsin Center for Health Sciences functions as a university-based, private group practice. The records of 251 newborn infants, followed in the practice between January 1, 1975 and December 31, 1976, were reviewed and included in this study.

The vast majority of infants were discharged from the hospital on days three to five with their mothers. All were seen for the first health supervision visit routinely at three weeks of age. An earlier appointment was made only if the physician, nurse practitioner, or parents anticipated a problem.

Some of the infants were taken off breast milk for 24 to 48 hours when the bilirubin levels reached 12 mg per dl, and they usually received phototherapy for bilirubin levels above 15 mg per dl. All infants had the following tests performed prior to receiving phototherapy: hemoglobin, hematocrit, and blood smear. The blood of the mother and infant were typed, and a Coombs test was performed. Evaluation for sepsis was performed when it was thought to be appropriate by the attending pediatrician. Three infants who had evidence of blood incompatabilities were eliminated from this study.

RESULTS. ***Incidence of hyperbilirubinemia:*** Two hundred and six (82.1%) of the 251 infants studied were breast milk fed. One hundred twenty-two (48.6%) of the neonates were boys and 129 (51.4%) were girls. One hundred six (86.9%) of the 122 boys were breast fed and 100 (77.5%) of the 129 girls were breast fed.

This study was performed when Doctor DeAngelis was Director of the Ambulatory Pediatric Services, and Doctor Sargent was a Fellow, at the University of Wisconsin Hospitals, Madison. Doctor Chun is Associate Professor of Pediatrics, Center for Health Sciences, University of Wisconsin Medical School, Madison, Wisconsin. Doctor DeAngelis currently is Associate Professor of Pediatrics and Director, Pediatric Primary Care, The Johns Hopkins Hospital, Baltimore, Md. Doctor Sargent currently is in Brookline, Mass. Reprint request to: Catherine DeAngelis, MD, Pediatric Primary Care, The Johns Hopkins Hospital, Baltimore, Md 21205 (Phone: 301/955-6143). Copyright 1980 by the State Medical Society of Wisconsin.

Table 1—Bilirubin levels in breast milk fed (BMF) *vs* formula fed (FF) infants

	10-12 mg/dl	*12-15 mg/dl*	*15 mg/dl*	*Total*
BMF (206)	12 (5.8%)	27 (13.1%)	14 (6.8%)	53 (25.7%)
FF (45)	1 (2.2%)	2 (4.4%)	1 (2.2%)	4 (8.9%)

Table 2—Hyperbilirubinemia (>10 mg per dl) by month of year

Month	*Number of Newborns*	*Hyperbilirubinemia* *Number*	*Percent*	*Average number of sunshine hours per month*
January	23	3	13.0	125
February	13	5	38.5	138
March	17	6	35.3	191
April	14	2	14.3	223
May	23	4	17.4	281
June	20	0	0	289
July	24	3	12.5	342
August	26	4	15.4	260
September	23	9	39.1	240
October	21	6	28.6	210
November	20	7	35.0	137
December	27	8	29.6	113

There was a significantly greater risk ($p<0.01$) for hyperbilirubinemia (total bilirubin greater than 10 mg per dl) in the breast milk fed (BMF) infants, 53/206 (25.7%), compared to the formula fed (FF) infants 4/45 (8.9%) (Table 1).

Forty-one (19.9%) of 206 breast fed infants had bilirubin levels over 12 mg per dl compared to 3 (6.7%) of the 45 bottle fed infants ($p<0.03$).

There was no significant difference in BMF, 14/206 (6.8%), versus FF, 1/45 (2.2%), infants who had bilirubin levels over 15 mg per dl. However, 10 BMF infants had been taken off breast milk at bilirubin levels of 12 mg per dl.

Peak Day: Bilirubin levels peaked at day 4.0 in FF infants with a range of 2 to 6 days. Bilirubin levels peaked at day 5.6 in BMF infants with a range of 3 to 10 days. The peak and range of days would probably have been greater especially in the BMF infants because 23 of the 53 with jaundice had either been taken off breast milk or had received phototherapy.

Prolonged hyperbilirubinemia: One FF infant had hyperbilirubinemia (>10 mg per dl) up to day 10. Thirteen (6.3%) BMF infants had hyperbilirubinemia more than 10 days and the longest recorded was 31 days.

Seasonality of hyperbilirubinemia: Table 2 shows the percentage of all infants, born in given months, who had bilirubin levels over 10 mg per dl. There was a definite preponderance of jaundice during the fall and winter months of the year. Thirteen (12.1%) of 107 infants born during the months of April through August had hyperbilirubinemia versus 44 (30.6%) of the 144 infants born during the other months. The only month that did not conform to the above was January.

Incidence of phototherapy: One (2.2%) of 45 FF infants compared to 14 (6.8%) of 206 BMF infants received phototherapy. There was no statistically significant difference between these groups.

However, 10 BMF infants had been taken off breast feeding when their bilirubin levels reached 12 mg per dl. Only one (10%) of these 10 infants subsequently received phototherapy while 13 (30.2%) of the other 43 BMF infants who had not been taken off breast milk at 12 mg per dl received phototherapy.

DISCUSSION. This study further documents the entity of breast milk jaundice. The delayed time for reaching peak levels of bilirubinemia with an average of 5.6 days and ranging up to 10 days is much shorter than that reported by Gartner et al[14] in 1966. In their study peak bilirubin levels were reached in an average of 13.7 days with a range of 5 to 27 days. It is difficult to understand the discrepancy. It might have some relationship to the environmental differences between New York and Madison. In any case both studies should alert physicians to the danger of early discharge of the BMF infant from the hospital without careful followup. Parents

should be taught to watch for increasing jaundice and to call the physician if it occurs.

The further documentation of the prolonged nature of breast milk jaundice shows that costly evaluations for liver disease in most BMF infants with this phenomenon is unnecessary. In 9 of 10 cases the bilirubin levels dropped when breast milk feeding was stopped. In the single case where it did not, the trial off breast milk probably had been too short.

In most cases the infants had to be off breast milk for 24 to 48 hours before breast feeding could be restarted. It is interesting to note that in only one case the mother chose not to resume breast feeding, but she had had many doubts regarding breast feeding prior to the hyperbilirubinemia problem.

The seasonal variability of jaundice is striking. The incidence of hyperbilirubinemia between April and August (12.1%) is significantly ($p<0.01$) lower than that during the other months (30.6%) with the exception of January when the incidence was 13.0%.

One explanation pursued was that hyperbilirubinemia was less prevalent during months with a high number of sunshine hours (Table 2). During the months of April through August there was an average number of 279 sunshine hours per month compared to 196.7 sunshine hours during the other months. Sunshine may have an effect on hyperbilirubinemia even though the infants are not deliberately exposed to it. However, other factors, such as degree of hydration, also may be involved.

The risk for phototherapy was not significantly different in BMF (6.8%) and FF (2.2%) infants. However, there was a three times greater risk for BMF infants to receive phototherapy if they had not been taken off breast milk at bilirubin levels of 12 mg per dl (30.2%) compared to those who had been taken off breast milk (10%). As with any retrospective study, it is impossible to tell what would have happened. However, it seems realistic to assume that a significantly higher risk for phototherapy would have occurred if no BMF infants had been taken off breast milk.

It can be argued that full-term infants with bilirubin levels of 15 mg per dl should not receive phototherapy. On the other hand, in 1971 it was reported that infants who had serum bilirubin levels in excess of 15 mg per dl for more than 72 hours during the first week of life were at risk to show cognitive dysfunction when tested at five years of age.[11] These observations have recently been confirmed.[16] It has not yet been determined whether those infants who exhibit prolonged hyperbilirubinemia associated with breast feeding during the second week or later in life are at a similar risk for bilirubin encephalopathy.

Management of infants with breast milk jaundice is a frustrating problem for the practicing pediatrician. The following factors must be considered: (1) the benefits of breast feeding are still far greater than any documented detriments to the infant, (2) the risks of phototherapy must be carefully weighed against possible benefits,[17] and (3) much more information about the phenomenon of breast milk jaundice and its possible long-term sequalae is needed.

Until more information is known, the approach advocated by the authors is to carefully monitor all BMF infants for hyperbilirubinemia for at least the first three weeks of life. If serum bilirubins reach a level of 3 or 4 mg per dl below that perceived by the physician as requiring phototherapy, breast feeding should be stopped for 24 to 48 hours. The parents should receive psychological support during this time to assure the resumption of breast feeding. Alternatively, formula feedings can be alternated with breast feedings until the bilirubin levels have decreased and stabilized. Phototherapy should be used only when discontinuing breast milk feedings fails to decrease the hyperbilirubinemia.

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REFER TO—Opitz JC: Idiopathic pulmonary hemosiderosis (report of a six-week-old infant who is now in clinical remission). *Wisconsin Med J* 79:43-47 (Feb) 1980

KEY WORDS—Hemosiderosis

Idiopathic pulmonary hemosiderosis

(Report of a six-week-old infant who is now in clinical remission)

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• *Primary idiopathic pulmonary hemosiderosis was diagnosed in a six-week-old infant, the youngest living child in whom this diagnosis has been confirmed. Change to a diet free of cow's milk was accompanied by clinical remission that has been sustained for at least 12 months. Recent immunologic and histologic investigations into the pathogenesis of this disease are reviewed.*

Idiopathic pulmonary hemosiderosis is a rare disease; however, it is being diagnosed more frequently. It is seen more often in children than in adults and is characterized by recurrent iron-deficiency anemia in association with pneumonic hemorrhagic lesions. Although its etiology is unknown, the disease may be associated with hypersensitivity to cow's milk. Infants have been reported to improve after removal of cow's milk from their diet.

The purpose of this paper is to describe primary idiopathic pulmonary hemosiderosis in a child of two months in whom the disease in all likelihood began before six weeks of age, making her the youngest such child whose condition was diagnosed *before* death and to review the recent literature. Clinical remission followed a diet free of cow's milk, although there was no evidence of milk precipitins or an increased level of IgE in the serum.

CASE REPORT. ***History.*** This white female infant was born on July 8, 1977 with a birth weight of 2814 gm. She was well until six weeks of age, when she began having intermittent episodes of hemoptysis. The blood that was expectorated was bright red and occasionally mixed with formula. She was on Similac® formula, which she continued to take eagerly. There were no associated swallowing difficulties or rhinorrhea. The mother noted occasional episodes of coughing but there was no evidence of wheezing or dyspnea. The mother noted that when the infant would "spit up the blood" it was usually after a coughing episode and not associated with vomiting. She was first seen at the Marshfield Clinic at age two months, on September 7, 1977.

Examination. Head circumference 36.0 cm (3rd percentile), weight 3662 gm (1st percentile), length 54.6 cm (10th percentile), and temperature 37.8 C.

This infant did not appear acutely ill or toxic. She demonstrated mild pallor. There was no evidence of cardiopulmonary distress.

Laboratory and x-ray. White blood county was 14,400 per cu mm with 31% lymphocytes, 9% monocytes, 3% eosinophils and 57% segmented neutrophils; peripheral smear revealed hypochromia and microcytosis; hemoglobin level - 9.0 gm per dl; hematocrit reading - 25.3%; platelet count 400,000 per cu mm; reticulocyte count - 3.0%; prothrombin time 11.5/11.5 (patient time/control); activated partial thromboplastin time - 31/30 (patient time/control); urinalysis - normal; mean corpuscular volume - 79 per cu ug; mean corpuscular hemoglobin - 28.6 uug; mean corpuscular hemoglobin concentration - 36.1%; serum thyroxin - 11.5 mcg per dl; serum ferritin - 186 mg per ml; serum iron - 59 mcg per dl; iron-binding capacity - 291 mcg per dl; total serum protein 6.3 gm per dl with albumin - 3.97 gm per dl, alpha 1 globulin - 0.15 gm per dl, alpha 2 globulin - 0.76 gm per dl, beta globulin - 0.61 gm per dl, gamma globulin - 0.81 gm per dl. Immunoglobulin consisted of IgG - 720 mg per dl; IgA - 31 mg per dl; IgM - 140 mg per dl; IgE - 24.8 ug per ml. The Westergren sedimentation rate - 30 mm per hour. Standard double immune diffusion against three concentrations of unpasteurized defatted cow's milk showed no precipitins to be present in the serum. Precipitating antibodies to milk proteins were tested for by the Scheidegger micro-Ouchterlony technique routinely used for precipitin testing for farmer's lung disease in this laboratory.[1] Straight

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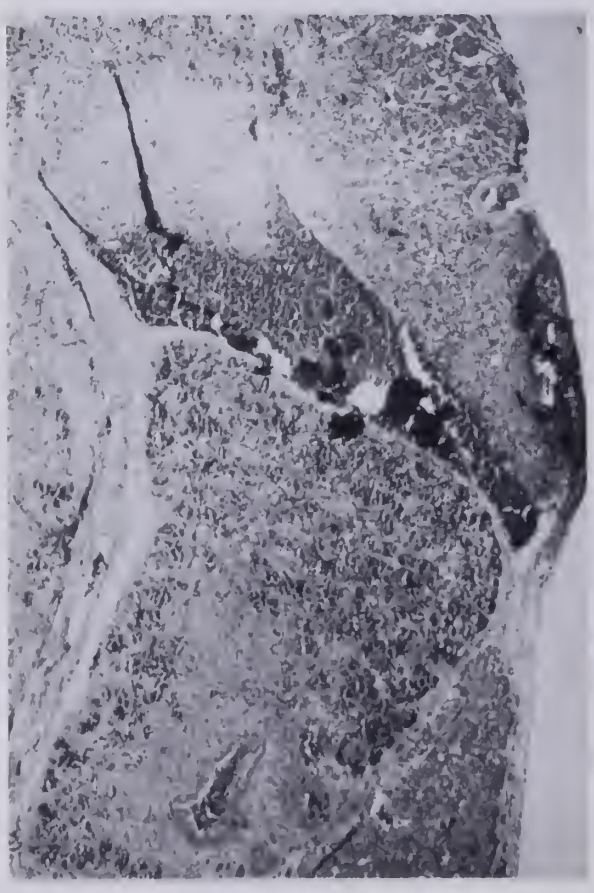
Figure 1—Chest radiograph revealing densities in the upper medial right lung.

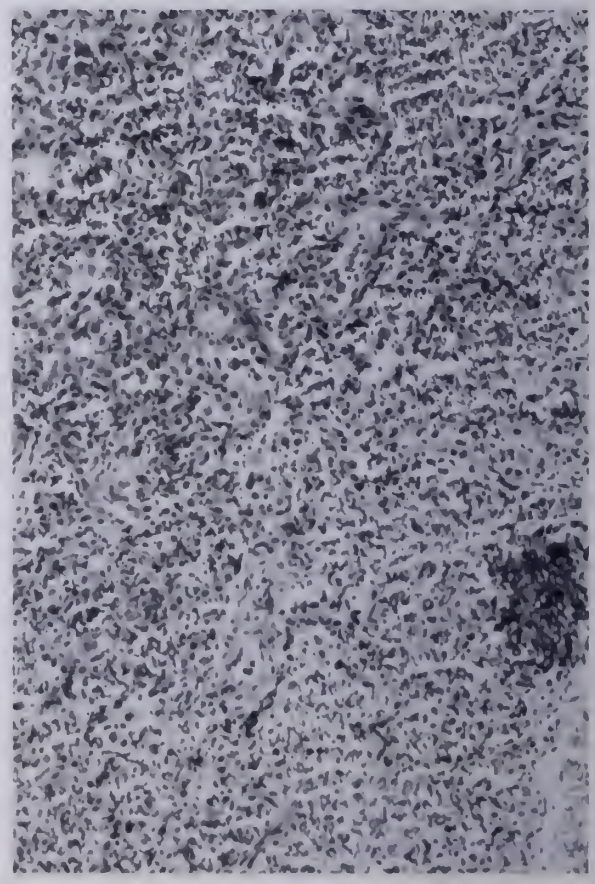
Figure 2—Low-power microscopy demonstrating intraalveolar hemorrhage with acute and chronic inflammatory changes along with macrophage infiltration.



defatted raw milk, 1:4 and 1:8 dilutions (10 ul samples) of the milk were placed in the peripheral wells and the 50 ul of the test serum was placed in the center well. Normal, negative controls were always included in the tests, but positive controls were not available. Bacteriology, viral, mycoplasma, pertussis, and Chlamydial studies were all negative. Initial gastric aspirate studies for hemosiderin-laden macrophages were negative but became positive on September 21, 1977 (this was after patiently waiting two weeks for patient to "spit up" mucus containing blood and then quickly examine the sample). Repeated chest radiographs revealed migratory infiltrates in the upper medial right lung, right lower lung, and left lower lung (Fig 1). Her pulmonary disease, however, was primarily right-sided. Electrocardiographic studies were normal.

Course. During the initial hospitalization, she remained stable but did continue to have occasional episodes of hemoptysis. Purified protein derivative (intermediate) was applied which was negative. Because of the need for documenting the clinical diagnosis, bronchoscopy and open lung biopsy were performed on September 28, 1977. No abnormalities were noted at bronchoscopy. Stained aspirates revealed no siderophages. The lung, on inspection, did not appear remarkable except for slight firmness

Figure 3—High-power examination demonstrating several pulmonary lobules with extrabronchial and intraalveolar hemorrhage.



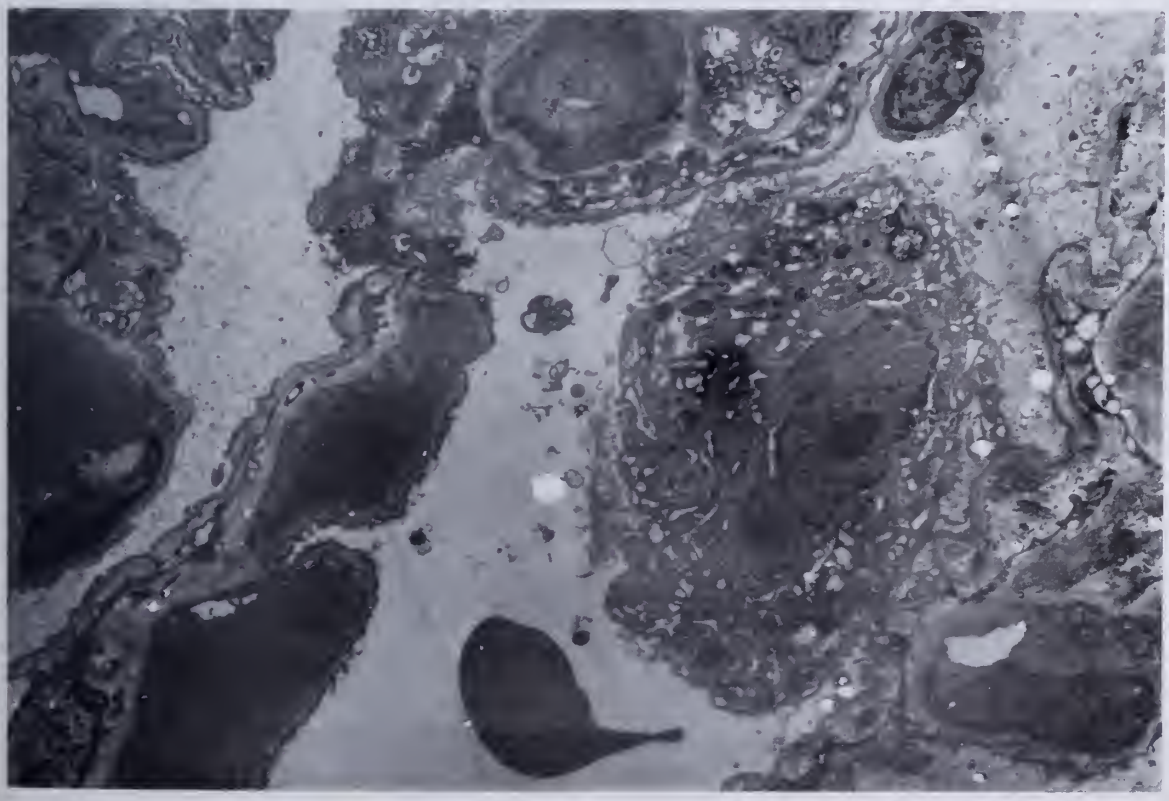
and nodularity in several areas. Microscopic examination of the lung tissue revealed abundant recent alveolar hemorrhages associated with macrophages containing hemosiderin. Septa showed increased cellularity with mononuclear cells. The alveolar lining demonstrated reactive cuboidal alveolar cells with hyperchromatic nuclei (Fig 2,3). Electron microscopy revealed no evidence of protein deposits within the capillary basement membrane or fragmentation or splitting of the basement membrane (Fig 4). Postoperatively she did well. She was placed on a cow's milk-free diet (Isomil®) and rather abruptly had no further evidence of pulmonary bleeding. She was discharged on October 10, 1977 and followed in the Clinic. On November 17, 1977 chest x-ray films were normal and the hemoglobin level was 11.4 gm per 100 ml. She has remained asymptomatic and was last seen in January 1979.

COMMENT. Idiopathic pulmonary hemosiderosis appears to be a distinct clinical and pathologic entity largely limited to children and young adults. There are many clinical reports reviewing the literature of this entity. Repetto, et al[2] studied 11 cases over a 10-year period and noted the predominate findings of iron-deficiency anemia and mild recurrent hemoptysis. Chest radiographs revealed permanent reticulation and miliary-type stippling in those cases that progressed to pulmonary fibrosis. Pulmonary function studies were performed in some of the patients. Diffusion capacity at rest was decreased in three of the four patients in whom the test was performed. Wigod[3] reported a three-month-old infant who presented with a hemoglobin of 2.0 gm per dl and survived until age 15 months.

In 1962 a review of the literature[4] revealed a total of 108 cases of idiopathic pulmonary hemosiderosis reported. In this group only 21 were over 15 years of age at onset of symptoms. The age distribution appeared sporadic and there was no predilection for sex, season, or a particular geographic area. There was no evidence of genetic predisposition. The average duration of symptoms until death was two and one half years. Most patients who survived for several years developed chronic dyspnea with associated pulmonary fibrosis. It was the impression of these authors that the primary abnormality was one of "pulmonary alveolar epithelial growth and function" resulting directly in alveolar capillary bleeding.

In Greece 26 patients were reviewed in 1968.[5] Age range was six months to nine years. There was noted a high incidence of hepatosplenomegaly. It is unusual to find râles in these children, despite their acute pulmonary illness. Radiographic findings were striking despite the minimal physical findings. It was interesting that there was a set of possible monozygotic twins and also a high incidence of consanguineous marriage in this series, suggesting

Figure 4—Electron microscopy revealing no definitive abnormalities of the pulmonary capillary or epithelial basement membrane.



possible genetic factors. Other earlier reviews worth consulting are those by Soergel[6] and Irvin.[7]

The pathogenesis of this disease remains perplexing. An immune mediated mechanism has been pursued by several investigators. Heiner et al[8] in 1962 described four infants with pulmonary hemosiderosis who, they believed, were hypersensitive to cow's milk. Symptoms disappeared after removal of cow's milk from the diet. In a later paper[9] the same author reported elevated IgE values in two of six subjects with pulmonary hemosiderosis. These two patients had evidence of clinical sensitivity to cow's milk, with symptoms abating after removal of cow's milk from the diet and exacerbations occurring when it was reintroduced. They also had precipitins to several constituents of cow's milk in their serum. The author suggested that patients with "idiopathic" pulmonary hemosiderosis can be divided into two groups: one having both clinical and laboratory evidence of reaginic hypersensitivity to cow's milk protein and the other not demonstrating this finding. Archer[10] described a patient obviously in the second group. Matthews, et al[11] demonstrated complement activation after milk feeding in children with cow's milk allergy, further supporting involvement of an immunologic mechanism in cow's milk allergy. A selective increase in serum IgA was noted in 31 children with idiopathic pulmonary hemosiderosis.[12] This has not been confirmed by other reviews of case reports.

There remains no direct cause-effect relationship of antibodies to cow's milk protein and pulmonary hemosiderosis; however, the association does seem to exist in some patients. Boat and associates[13] screened 160 children with idiopathic chronic lung disease and found six with high titers of milk precipitins. These children all had typical manifestations of milk-induced pulmonary hemosiderosis.

Further immunologic studies[14] in cow's milk-induced pulmonary hemosiderosis have been performed utilizing radioallergosorbent tests. Lymphocyte response to cow's milk protein was also done. Studies were carried out in nine patients with precipitins to cow's milk. Three had pulmonary hemosiderosis, one suspected pulmonary hemosiderosis, three had nonhemosiderosis chronic lung disease, and two had other diseases. The author concluded that "the quantity and immunoglobulin class distribution of antibodies to cow's milk protein were similar in all patients" and that the quantity of antibody to cow's milk protein was greater in the patients than in age-matched controls. The lymphocyte response to cow's milk protein was studied in three patients with pulmonary hemosiderosis, three patients with other diseases associated with milk hypersensitivity, and nine negative control subjects. The three patients with pulmonary hemosiderosis and the three with other types of milk hypersensitivity had greater tritiated thymidine incorporation than the negative control subjects. These observations neither ruled in or out a role for hypersensitivity to cow's milk in the pathogenesis of pulmonary hemosiderosis, but suggested that milk precipitins themselves do not have a consistent relationship to the disease.

Electron microscopy has become important for studying the pathogenesis of this disease, and resulting studies[15,16,17] suggest a primary structural defect in the wall of the pulmonary capillaries. A lung specimen from a 21-year-old man with pulmonary hemosiderosis[15] showed widespread abnormalities of the pulmonary capillaries. Swollen endothelium and dense protein deposits within the capillary basement membranes suggested possible "immunue complexes." Ultrastructure studies of a 35-month-old child with idiopathic pulmonary hemosiderosis[16] revealed breaks in the continuity of the basement membrane. Electron microscopy of the pulmonary capillaries and epithelium of the described patient revealed no definitive abnormalities. However, efforts to implicate an immune-mediated mechanism for the effect in this patient were unsuccessful. Total serum complement and serum immunoproteins were normal and no deposits of immunoproteins were observed on capillary basement membranes by electron microscopy and immunofluorescent techniques.

It would be difficult to state in which of Heiner's two categories[9] that our infant should fall. No conclusion can be drawn from our case report. We acknowledge a report[18] of pulmonary hemosiderosis diagnosed in a three-week-old infant after death, but we are not convinced that this was indeed idiopathic and not secondary pulmonary hemosiderosis. The purpose of this report is to describe the youngest case of idiopathic pulmonary hemosiderosis that has been diagnosed antemortem and to review pertinent literature related to pathogenesis. It is important to remember that there are many systemic pathologic events that can result in acute, chronic, or intermittent pulmonary hemorrhage and the associated finding of hemosiderin-laden macrophages in the tracheal effluent.

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REFER TO: Sty JR, Babbitt DP, Starshak RJ: Neonatal pancreatico-biliary reflux secondary to an annular pancreas. *Wisconsin Med J* 79:47-48 (Feb) 1980

KEY WORDS: Duodenum, duodenum obstruction, annual pancreas, biliary reflux

Neonatal pancreatico-biliary reflux secondary to an annular pancreas

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Incompetence of the sphincter of Oddi in the newborn is extremely uncommon. The literature refers to several cases in which air or barium refluxed into the biliary tract, but not the pancreatic ducts during upper gastrointestinal examination.[1-3] The incompetence of the sphincter in all cases was associated with partial or complete duodenal obstruction.[4]

CASE REPORT. A 4-day-old male was transferred to the hospital with a history of vomiting after feeding. He was the product of an uncomplicated pregnancy and delivery. Preliminary radiographs demonstrated a distended, air-filled stomach and duodenal bulb. Minimal gas was present in the distal small intestine and colon. An upper gastrointestinal x-ray series demonstrated reflux of barium into the common bile duct and pancreatic ducts (Fig 1). The duodenal bulb was markedly distended, secondary to an incomplete duodenal obstruction.

At surgery an annular pancreas was documented. A duodeno-duodenostomy was performed without exploration in the region of the sphincter of Oddi. A postoperative upper gastrointestinal x-ray series demonstrated no reflux in the common bile duct or pancreatic ducts.

From Department of Radiology, Milwaukee Children's Hospital. Reprint requests to: John R Sty, MD, Dept of Radiology, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, PO Box 1997, Milwaukee, Wis 53201 (Phone: 414/931-1010). Copyright 1980 by the State Medical Society of Wisconsin.

DISCUSSION. There are numerous causes of gas or barium reflux within the biliary tract in the adult (Table 1). However, identification of gas in the biliary tract in the neonate is due to high intestinal obstruction. In the case presented barium was refluxed into the biliary tract as well as the pancreatic ducts during an upper gastrointestinal examination. Reflux into the biliary tract is rare, and we were not able to find a report of reflux into the pancreatic ducts. The mechanism of reflux is unclear. The incompetence of the sphincter of Oddi may be due to anatomic factors[5] or elevated intraluminal pressure.

Table 1—Etiology of gas in the adult biliary tract

1. Incompetence of sphincter
   - Obstruction
   - Unknown
2. Fistula
   - Gallstone erosion
   - Duodenal ulcer perforation
   - Tumor erosion
3. Infection
   - Emphysematous cholecystitis
4. Postsurgery
   - Bypass surgery
   - Sphincterotomy

HEMOSIDEROSIS continued

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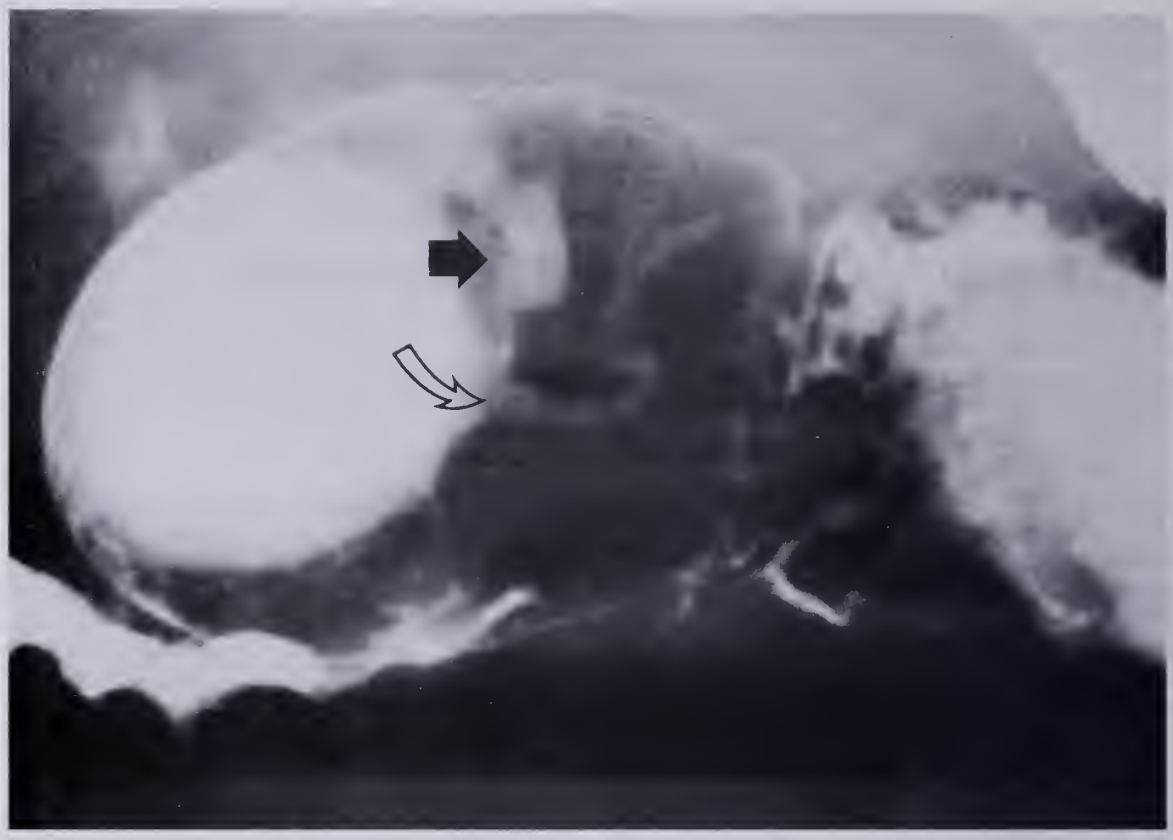

Figure 1—Radiograph of duodenal bulb. Solid arrow marks entrance of common bile duct into duodenum. Curved arrow marks pancreatic duct.

The postoperative upper gastrointestinal x-ray series which demonstrated an absence of reflux suggests that elevated intraluminal pressure is at least a contributing factor.

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Abstracts

CT detection of demyelinated plaques in multiple sclerosis

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Am J Roentgenol 132:213-215 (Feb) 1979

In one-third of patients with clinically diagnosed multiple sclerosis, focal abnormalities can be detected by computerized tomographic (CT) scanning. To determine what factors affect CT detection of demyelinated plaques, we correlated CT and anatomic findings in two cadaver brains with demyelination. The brains were first imaged in a General Electric CT/T 8800 with 5 mm slice thickness and high milliamperage techniques. Subsequently, the brains were fixed and sectioned with an electric slicer into 5 mm thick axial sections corresponding exactly to the CT images. Plaques identified by the radiologist examining CT images and the neuropathologist examining the brain specimens were correlated. Demyelinated plaques smaller than 0.7 cm were, in general, not detected by CT. Some larger plaques were misinterpreted as part of a ventricle or sulcus. Chronic demyelinated plaques can be detected but not excluded by CT. ■

REFER TO: Timming RC, Cayner JJ, Grady S, Grafman J, Haskin R, Malec J, and Thornsen C: Multidisciplinary rehabilitation in severe head trauma. *Wisconsin Med J* 79:49-52 (Feb) 1980

KEY WORDS: Head trauma, rehabilitation, brain injury

Multidisciplinary rehabilitation in severe head trauma

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Head injury is a major cause of death and disability in this country, especially in the age group 1 to 44 years.[1] Head trauma can result in chronic physical, psychological, and social deficits which affect the patient, family, and community. Severe disability in this young age group will have long-range implications, both economic and in terms of human suffering.

Experts in rehabilitation often feel frustrated in dealing with the multiple complex problems of the head-injured person months or years after onset. Rusk[2] in 1969 pointed out that patients with brain damage following trauma were a neglected group from a rehabilitation point of view. This situation does not appear to have changed substantially. Studies on the rehabilitation outcome of the brain-injured person are difficult to assess and compare because of differences in patient population and outcome criteria. Current debate questions whether significant physical/psychological recovery occurs within the first six months following injury, or can occur even several years later.[3]

The following is a description of a multidisciplinary rehabilitation program for a young man with severe physical, cognitive, and interpersonal problems persisting from a head injury ten years ago.

PATIENT DESCRIPTION. This 30-year-old man sustained a severe head injury in July 1969. He was reportedly comatose for three months with a post-traumatic amnesia of approximately nine months. A tracheotomy was required. The patient participated in a rehabilitation program from May through December 1970 in New York. He had one additional rehabilitation effort from March to June 1973. The patient lived with his mother and worked at a sheltered workshop facility with severely retarded individuals.

Examination showed him to be cooperative and oriented to time, person, and place. However, he was very talkative and had difficulty sticking to the topic. The patient complained of memory problems. Cranial nerves were intact. Left hemiparesis was present with bilateral hyperflexia and bilateral Babinski sign and mild spasticity. Ataxia of all four extremities and trunk was present, worse on the left. The patient demonstrated a broad-based, stereotyped gait on the left and tendency of the left knee to go into back knee. Cortical and peripheral sensory modalities were grossly normal. Speech was intelligible with no definite dysarthria.

The patient underwent baseline assessment by a multidisciplinary rehabilitation team. Pertinent goals were established at an evaluation conference and a treatment program initiated.

TREATMENT METHOD. Major treatment goals in Physical Therapy were to walk using one cane instead of two, improving balance, and coordination. The patient was placed on an exercise program and a supervised gait-training program to help implement improvements.

In Occupational Therapy the patient participated in an assessment of strength, endurance, range, and coordination of his upper extremities. An exercise program emphasizing upper extremity coordination was instituted. Recreational Therapy provided leisure time activities and an opportunity to practice newly learned social skills. Memory skills were also reinforced by teaching the patient new recreational skills.

Initially the patient was referred to the Neuropsychology Laboratory for a comprehensive cognitive evaluation. On this evaluation the patient demonstrated average scores on tests of psychometric intelligence (Weschsler Adult Intelligence Scale [WAIS]; verbal IQ 110, performance IQ of 93, and full scale score of 103) and on other verbal and nonverbal abstraction and concept for-

From Rehabilitation Medicine, Social Work, Physical Therapy, Neuropsychology, Vocational and Education Services, Clinical Psychology, and Occupational Therapy, University of Wisconsin-Madison, Center for Health Sciences, Madison, Wisconsin. Reprint requests to: Richard C Timming, MD, UW-Madison, Dept of Rehabilitation Medicine, Clinical Science Center E3/350, 600 Highland Ave, Madison, Wis 53792 (Phone: 608/263-8640). Copyright 1980 by the State Medical Society of Wisconsin.

mation measures. His outstanding deficit was difficulty in transferring and consolidating information from short to intermediate and long-term memory.

Subsequently the patient received a detailed memory evaluation and retraining. The patient's baseline memory evaluation suggested a predominantly verbal memory deficit that was partially attributable to an attentive-discriminative problem. The attentive problem is illustrated by the patient's excessive verbal output during the testing which did not allow him to process completely significant verbal or nonverbal input. On a word learning test a considerable proportion of intrusive errors (*i.e.,* recalled words not in the list) were indicative of the patients tendency toward inappropriate verbal production. Such intrusive items were believed to interfere with the processing of material to be learned. Memory difficulties were observed on other tests as well. For instance on a test that requires recognition of the approximate date of famous events (long-term recall) the patient performed in the impaired range, correctly matching the date with the event in only 22 out of 40 items; this despite his being a "history major" in college.

The patient participated in memory retraining for approximately four weeks (18 one-hour sessions). Mnemonic strategies that were taught included imagery, method of loci, and the PQRST method. (A description of these strategies can be found in Grafman and Matthews[4] or may be obtained by writing the Neuropsychology Laboratory at University of Wisconsin Hospital and Clinics). The patient exhibited considerable facility in learning and adapting these strategies to the various memory tasks that were presented to him during the retraining sessions and extra therapy assignments.

Social Services evaluated interpersonal, personal, and familial resources. Casual observation, reports from significant others, and role-play tests demonstrated interpersonal difficulties in: (1) asking other people questions, (2) allowing others to enter conversations, (3) use of nonverbal gestures and, (4) ter-

TABLE 1. Changes in selected neuropsychological and memory tests from before to after inpatient rehabilitation treatment.

TESTS ADMINISTERED	IMPROVED PER-FORMANCE	BASELINE SCORE	SECOND EVALUATION SCORE
Word Fluency Test (# words)	+ +	35***	41*
Token Test (# errors)	+	5*	1*
Word List I (% correct)		.56***	.56***
Word List II (% correct)		.89*	.89*
Sentences I (% correct)		.92*	.92*
Sentences II (% correct)		.75***	.75***
Paired-Associates/high (% correct)	+	.13****	.38****
Paired-Associates/low (% correct)		.06*****	.06*****
Selective Reminding (X recall)	+ +	6.1***	7.9**
7/24 Test (% correct)		3,1,1*	3,1,1*
Facial Recognition Test (% correct)		45*	43*
Recurring Figures Test (% correct)	+ +	8*****	29***
Current Events Test (% correct)	+	.55***	.58***

CATEGORY
Normal range - *
Borderline - **
Mild impairment - ***
Moderate impairment - ****
Severe impairment - *****

IMPROVEMENT
Within a category - +
Across a category - + +

For a more detailed test description and rationale for their use, see Grafman and Matthews (1978, in press).

minating or closing a conversation. In addition to this all therapists initially found the patient difficult to work with, describing him as "set in his ways, close-minded, immature, garrulous."

The Clinical Psychology interview revealed behavioral tendencies similar to those recorded by the Social Worker. As part of the Clinical Psychology evaluation, the patient completed the Symptom Check List (SCL-90) and a shortened version of the Minnesota Multiphasic Personality Inventory (MMPI-168) (Fig 1). These self-report inventories are measures of disturbed personality functioning. The MMPI personality profile suggested that the patient was extroverted, valued social attention and reinforcement, tended to be self-centered and energetic — perhaps to the point of overactivity and feeling "driven" at times. The SCL-90 further suggested that the patient experienced mild social self-consciousness, discomfort in public, and tended toward egocentric overconcern with demonstrating personal competencies. Thus, personality measurement supported the clinical impression of a patient who tended to view interpersonal interactions from an egocentric, self-conscious perspective. From such a perspective the patient would likely view other persons as an audience, as evaluators, and as a source of social rewards, but not as peers to engage in mutually rewarding social exchange.

A time-out program[5] for excessive or off-task verbalizations was initiated. All rehabilitation staff utilized three sequential and escalating procedures to cue the patient when his talk became excessive or tangential.

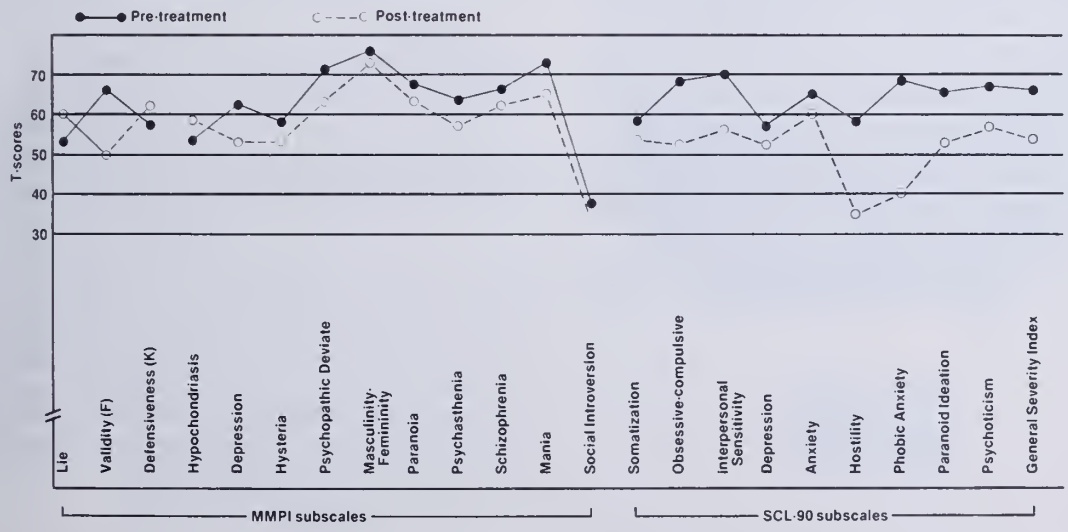
These procedures were: (1) breaking eye contact, by turning eyes/face away from the patient (maximum 15 seconds); (2) turn body away from patient (maximum 15 seconds); (3) walk away from patient. These social contingencies were fully explained to the patient and it was pointed out that these were merely exaggerations of common social responses he might encounter for rambling verbalizations. The patient fully agreed to this program and rehearsed the procedures with the therapists prior to initiation of the program.

In addition to the above program, new socially appropriate interpersonal skills were taught using modeling (therapist demonstration), rehearsal (patient practice) and videotaped feedback. These training sessions consisted of: (1) reviewing, defining, and/or discussing the desired communication skill; (2) demonstrating or modelling the new skill for the patient; (3) practicing the skill in a role-play situation; (4) reviewing the videotape with both therapist and patient rating the patient's performance.

RESULTS. By the completion of his Physical Therapy program the patient was able to ambulate with use of one cane. In addition he demonstrated improvement in gait and balance. In Occupation Therapy hand strength had improved to what would be considered average for age and sex. Although he had difficulty in fine manipulative tasks, he did well on tasks such as alphabetical and numerical filing.

With completion of the four-week, inhospital memory retraining program the patient was reevaluated with the same memory tests (Table 1). These performance score gains on 5 of 13 tests, while encouraging, do not fully represent the new strategies employed by the patient. He subsequently

Figure 1.
Personality profiles from Minnesota Multiphasic Personality Inventory (MMPI) and Symptom Checklist (SCL-90) before and after inpatient rehabilitation treatment



reduced his inappropriate responses from baseline testing, while actively displaying the mnemonic strategies learned during the retraining period. The patient showed increased word fluency and decreased extraneous conversation as compared to baseline.

At completion of social skill training the patient was able to use questions, pauses, and other interpersonal skills without prompting. Perhaps more important, other therapists and family agreed that the patient's social skill was significantly improved.

Measures of disturbed personality (MMPI-168 and SCL-90) decreased generally and indicators of psychopathology were entirely within average limits after treatment (Fig 1). Post-treatment profiles are typical of a person whose personal and interpersonal behavior is generally socially appropriate and not a source of personal distress.

DISCUSSION. The patient with severe disability resulting from head injuries has been often regarded as hopeless and a burden on society and the family. This young man showed significant improvement in his functional status with the help of a multidisciplinary brain-injury program ten years after the onset of his injury. Gait and balance improved such that he could ambulate with one cane instead of two, thus leaving the other hand free to open doors, write, carry objects, and the like. Perhaps even more important, memory, personality, and social skills improved such that at this point we feel this patient has a chance for competitive employment and a more independent living situation; that is, improved quality of life.

There are many persons throughout Wisconsin whose lives have been severely limited by the residuals of severe head trauma. Because of physical or psychological disabilities, these persons are not functioning at their maximum. A multidisciplinary brain-injury program may result in an improvement in their quality of life as well. Such persons may benefit from a multidisciplinary program designed to maximize their potential.

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Abstracts

Safety of changing intravenous delivery systems at longer than 24-hour intervals

JEFFREY D BAND, MD and DENNIS G MAKI, MD, Univ of Wisconsin Center for Health Sciences, Madison, Wis: *Ann Intern Med* 91:173-178 (Aug) 1979

Routinely changing the intravenous delivery system (fluid containers and administration set) every 24 hours is widely practiced in American hospitals to reduce the risk of septicemia caused by contaminated infusate. A prospective clinical study was made to ascertain whether changing at longer intervals could be justified. At the conclusion of infusion therapy through one system, both the cannula and an aliquot of remaining fluid were cultured quantitatively. Of 790 infusions, contaminated infusate was detected in one (39%) of 258 discontinued and sampled after one to 24 hours of continuous use, three (84%) of 359 after 25 to 48 hours, and one (58%) of 173 after 49 to 71 hours; none of these five contaminated systems produced septicemia. However, five cannula-related septicemias were identified during the study, none associated with concordant contamination of infusate. Routinely replacing the delivery system every 48 hours seems to be justified and could result in considerable savings to hospitals. Infection of the cannula wound and contamination of infusate seem to be unrelated. ■

Pulmonary abnormalities in art glassblowers

SHELDON R BRAUN, MD and ANASTASIOS TSIATIS, PhD; Univ of Wisconsin Center for the Health Sciences, Madison, Wis: *J Occup Med* 21:487-498 (July) 1979

Emphysema in glassblowers has been recognized as an occupational lung disease in some countries. Forty-seven art glassblowers at a recent convention answered a questionnaire and had pulmonary function studies performed. While this was generally a young, healthy population (mean age 34.5 years), 21% had "usual cough" and 31% had wheezing. Pulmonary functions were most often normal. However, VC and FEV_1 showed a significant drop with increase in the total lifetime hours exposed to glassblowing. Both the presence of a cough and the production of phlegm were related to hours of exposure. There may be some unknown toxic effect of art glassblowing that in the future may prove to be hazardous to health. ■

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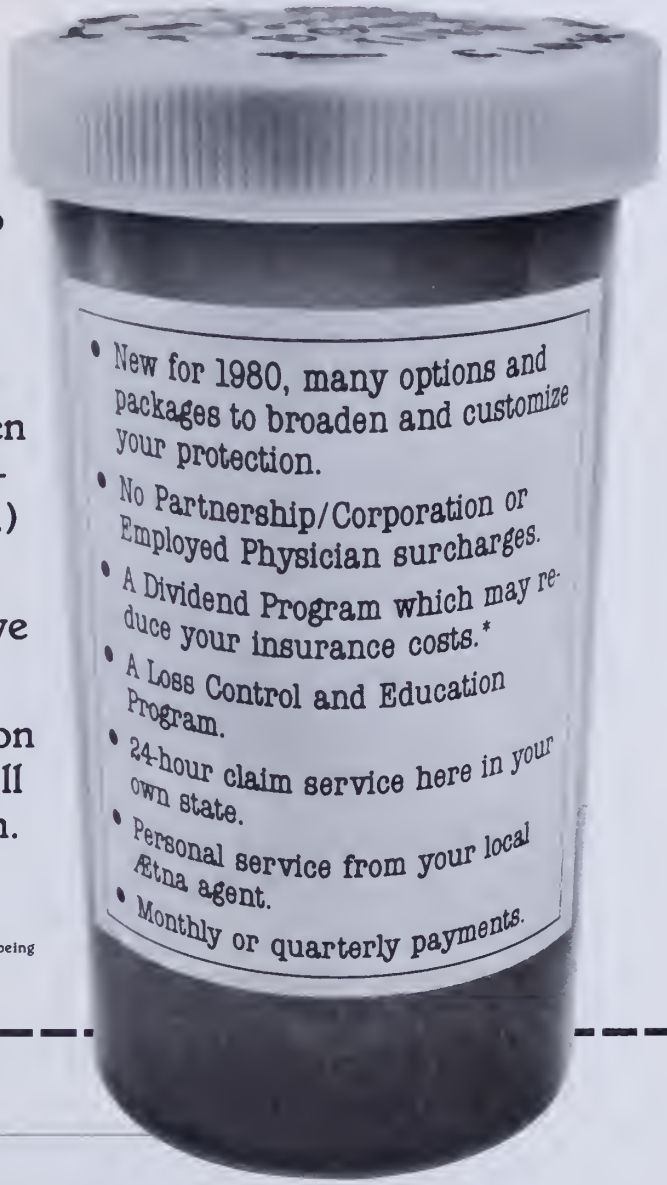

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Milwaukee Academy of Medicine: Archebald R Pequet, MD,* Wauwatosa, was elected president-elect of the Academy at its annual meeting in January. Chesley P Erwin, MD,* Milwaukee, assumed the presidency. Thomas J Russell, MD,* Milwaukee, was elected secretary. David J LaFond, MD,* Milwaukee, was elected treasurer. Nicholas F Geimer, MD, Wauwatosa, was elected librarian. Elected to the Council were MDs Richard B Bourne,* John R Litzow,* Harry A Easom,* William C Fetherston,* and George F Flynn,* Milwaukee, and Adam Fueredi,* Cedarburg.

Senior membership awards were presented to MDs William L Coffey Jr,* Norvan F Gordon, Jules D Levin,* and Hanno Mayer, all of Milwaukee.

In assuming the presidency Doctor Erwin briefly retraced the history of the Academy (as described in earlier inaugural addresses of Doctors Lee and Boulanger) from the time of Doctors Ogden and Brown, who were early, major figures in the history of the Academy and of the Milwaukee medical community of their period. He emphasized the major function that the library of the Academy of Medicine has played in the history of the Academy and spoke of its expanded facilities in the new Medical Education Building of the Medical College of Wisconsin. He foresaw for the Academy a bright future for the stimulation of scholarly pursuits at all levels in medicine, with the new library as a major means of affording such stimulation. Finally, he took the encouragement of quality in all aspects of medical practice as the essential function of the Academy.

The retiring president, Doctor Bourne, reported some of the Academy's accomplishments in 1979: Gained four more years of accreditation; the History of Medicine Room in the Todd Wehr Medical Library, Medical College of Wisconsin, began taking shape with some of the Academy's books already shelved; a special collections librarian was added to the staff of the library with responsibility to develop programs jointly with the Academy, to review the collection and determine how it might best be displayed and utilized; the Oral History Program now has 14 interviews on tape and it is now available to the medical community; even with rampant inflation the Academy remains solvent with no increases in dues; and elected 24 new members to the Academy.

The Milwaukee Academy of Medicine's library collection is now valued at $100,000.

Guest speaker for the Rogers' Memorial Lecture at the February 19 meeting of the Academy was Howard L Fields, MD, PhD, associate professor of Physiology and Neurology, University of California, San Francisco.

Guest speaker for the March 18 meeting will be Professor Iain Simpson, founder and head of the Institute of Neurological Sciences, Glasgow. ■

NEWS YOU CAN USE

SCREENING RECOMMENDATIONS FOR REFUGEES ISSUED. A report containing screening recommendations for Indochinese refugees entering the United States was mailed to all Wisconsin physicians in January by the State Dept of Health and Social Services. The report, prepared by the National Center for Disease Control, recommends routine screening of all refugees for tuberculosis, hepatitis B, and intestinal parasites, as well as initiation and updating of appropriate immunizations. Physicians who have questions regarding the report should contact State Epidemiologist, Jeffrey Davis, MD, at the Division of Health in Madison: 608/266-1251. ■

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*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:
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THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste, headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage Bentyl 10 mg. capsule and syrup *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily. *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults*. 1 tablet three or four times daily. Bentyl Injection: *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine* (bethanecol chloride USP) should be used.
Product Information as of October, 1978.

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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Organizational SMS

Health planning major topic at Council meeting

Health planning issues were the main topics for discussion January 19 when the Council of the State Medical Society met at SMS headquarters in Madison.

Concerned about the growing cost of the State's Certificate-of-Need program and its questionable effectivensss in containing costs and unnecessary duplication in the healthcare system, the SMS Council has requested the State Dept of Health and Social Services Secretary Donald Percy to conduct a cost-benefit evaluation of the CON program in Wisconsin. Such an evaluation, according to the Council, should compare the accomplishments of the program with the cost of operating it.

After receiving a status report from SMS Health Planning Commission Chairman Guenther Pohlmann, MD of Milwaukee, on the draft 1980-83 State Health Plan, the Council went on record as officially opposing strict application of the National Guidelines for Health Planning to the State Health Plan in order that the Plan can better meet the needs of Wisconsin's healthcare system. New amendments to the federal health planning law no longer require that state health plans "be consistent" with the federal guidelines. Yet, state planners, in drafting the 1980-83 State Health Plan, continued to apply the national guidelines to the obstetrical and perinatal services, surgical services, radiology, and general medical services sections of the Plan.

The Council also voted to create an Ad Hoc Committee on Alternative Health Care Delivery Systems to study the present and potential impact of health maintenance organization (HMO) and individual practice association (IPA) development in Wisconsin. The new committee will investigate the potential for establishing alternative healthcare delivery methods in Wisconsin that are more responsive to marketplace incentives.

In other action January 19, the Council:

- Was given status reports from Robert Carlovsky, MD, Fond du Lac, and Kermit Newcomer, MD, La-Crosse, regarding the Society's studies on Public Health and Physician Distribution in Wisconsin.
- Forwarded to the House of Delegates with favorable recommendation a proposed general revision to update the SMS Constitution and Bylaws. Constitutional amendments introduced in 1980 cannot be acted upon until the 1981 Annual Meeting.
- Merged the SMS Committees on Occupational Health and Rural Health with the Committee on Environmental Health.
- Nominated Councilor Irwin Bruhn, MD, Walworth, as the SMS representative to the Board of Directors of Wisconsin Health Care Review, Inc (WHCRI).
- Approved a net operating budget of $1,393,500 for 1980. Anticipated income for 1980 is $1,460,000, leaving projected additions to reserves of $66,500.
- Will recommend to the 1980 House of Delegates that 1981 SMS dues increase by 10.1 percent, or $35, in keeping with increases in the Consumer Price Index.
- Reaffirmed its present position on independent nurse practice stating that "the existing Nurse Practice Act is adequate for any role in which the nurse is practicing any act of medicine under the supervision of a physician, and that such supervision is essential." ■

Society testifies on involuntary commitment law changes

The State Medical Society urged adoption of a bill seeking to correct current deficiencies in Wisconsin's involuntary commitment law at a hearing before the State Senate Human Services Committee in late December.

The bill, SB 417, would amend involuntary commitment laws to require evidence of "substantial probability" of physical harm to oneself as "evidenced by recent overt acts" as cause for commitment.

Present law requires use of a "very substantial probability" standard.

Speaking on behalf of the State Medical Society, Health Planning Coordinator Neal Neuberger stressed that the Legislature has a "legitimate interest under its 'parens patriae powers,' (the state is the protector of all citizens) in providing care to its citizens who are unable to care for themselves because of emotional disorders." Present statutes, while drafted with good motives, have stressed legal rights to the detriment of quality care for those same persons the law seeks to protect," Neuberger said.

While SB 417 would be a step forward in addressing current problems in the mental health laws, the State Medical Society is concerned about two provisions in the bill, according to Neuberger. SMS believes the bill should be amended to restore provisions to allow a physician to treat individuals during an emergency commitment or detention period. Furthermore, the Society is seeking restoration of parents' rights regarding minors in involuntary commitment cases. ■

SMS Task Force criticizes Health Plan

At press time it was reported that the efforts of the SMS Physician Task Force and its chairman, Doctor Erlandson, and hundreds of irate citizens helped kill the hospital merger plan when it came up for approval at the Health Planning Council of Health Systems Agency I's steering committee meeting in late January.

State Rep Tom Loftus (D-Sun Prairie), chairman of the steering committee's subcommittee on excess capacity, offered a compromise proposal that called for establishing long-range plans by individual hospitals and groups of hospitals. This, too, was rejected.

Doctor Erlandson said the 40-member task force will continue to offer its assistance to the steering committee as it revises the regional health plan and further refines sections.

The SMS Physician Task Force in Health Systems Agency (HSA) 1 released a report in January criticizing the HSA's regional health systems plan and urged that the plan be rewritten to correct "glaring technical errors."

The Physicians Task Force in HSA 1 is part of the Society's Wisconsin Physicians Planning Network (WPPN) designed to increase physician participation in health planning.

In its report to the Health Planning Council Board of Directors, the Task Force, chaired by Jan Erlandson, MD, Monroe, charged that the health systems plan "was developed with almost no physician input and that persons involved in drafting the plan had a minimal understanding of how medical services were actually delivered in the region."

The Task Force urged that the plan be rewritten to "reflect the quality of medical care available to residents of South Central Wisconsin."

The physicians raised several major concerns in portions of the health systems plan dealing with: excess hospital capacity, open heart surgery and cardiac catheterization services, pediatric and perinatal services, human services, and radiotherapy services.

The plan's recommendations for reducing excess hospital capacity in the region through corporate consolidation of twelve hospitals—most of them rural—drew a considerable amount of criticism from the Physician Task Force.

"The report ignores the impact that hospital consolidation would have on access to primary care in rural areas, particularly access for elderly people," said the Task Force.

The physician group pointed out that hospitals where consolidation is proposed have in fact a lower per diem charge than most of the hospitals which would remain untouched under the plan's recommendations.

"The plan does not cite any evidence that smaller hospitals provide worse patient care than larger ones," the Task Force said. "In fact, hospital infection rates in large hospitals are far greater than in small hospitals which has a significant fiscal impact in and of itself."

The Task Force underscored the necessity for careful review of hospital services before sweeping recommendations are made—something the physicians charge was not adequately done by the Health Planning Council in its original draft of the plan.

"They really haven't gone out to the communities and talked to people and asked them what their needs are, what their situation is like, and how all of the suggestions would affect their care. Rather they continue to rely on the same old meaningless numbers, callously applying them as if the numbers were people," Physician Task Force Chairman Erlandson said. ■

CONTRIBUTIONS CES FOUNDATION DECEMBER 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for December 1979.

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State Medical Society—*Darrell S Sharp, MD; Harold May*

SMS annuity unit value: $2.93

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.93 as of December 31, 1979. This compares with $2.46 as of December 29, 1978 and $1.10 as of December 31, 1962. ■

Environmental Health Committee meets with DILHR Secretary Noll

Mobile home and pressboard manufacturers in the state must be given some time to adjust to a 0.2 ppm formaldehyde vapor standard and therefore a 0.4 ppm standard is reasonable the first year, Department of Industry, Labor and Human Relations Secretary Joseph Noll told members of the SMS Committee on Environmental Health in January.

Noll appeared before the Committee to discuss a formaldehyde vapor exposure standard the Department is considering and a topic in which the SMS Committee has taken a keen interest in recent weeks.

The SMS Committee previously recommended to Secretary Noll that the limit on formaldehyde vapors in mobile homes be set at 0.1 ppm. It based its recommendation on a study by the State Division of Health which reported formaldehyde-related illnesses in homes with formaldehyde levels of 0.4 ppm and below.

Illnesses included eye irritation; cough, sore throat or runny nose; shortness of breath or tightness of chest; headache, fatigue, vomiting, and diarrhea. In addition, infants in the affected homes often required hospitalization for gastrointestinal or respiratory problems.

Secretary Noll has recommended an administrative rule setting the standard at 0.4 ppm the first year and 0.2 ppm thereafter. Noll stated that while any standard will present an economic hardship to the mobile home industry in Wisconsin, the 0.1 ppm standard proposed by the Committee would present an enormous problem to the industry and result in substantial price increases in mobile homes.

He admitted that his Department was not used to dealing with medical topics and he asked that the Committee lend its medical expertise on the problem.

Public hearings on the proposed rule will be held in February. Noll said if the Department had reason to believe after these hearings that a 0.2 ppm standard was not strict enough, the Department would drop the standard to 0.1 ppm. ■

Few in-state physicians fail to comply with CME requirement

Examination by SMS staff of a Medical Examining Board list of some 200 in-state physicians who have not submitted proof of continuing medical credits or met other requirements for 1980-81 medical license re-registration has found the vast majority of the physicians to be either retired, or physicians who have since moved out-of-state. Additionally, a few physicians on the list contend they have complied, even though the Board's records do not so indicate.

In December 1979 the Medical Examining Board released a list showing some 800 Wisconsin physicians as not having met the 30-hour continuing medical education requirement for re-registration.

The deadline for submission of CME credits, the completed license renewal form, and license re-registration fee was December 31, 1979.

To comply with due process, however, the Board will not issue formal complaints against unregistered physicians *who are still practicing* until March 14.

SMS advises retired physicians who no longer wish to maintain an active license to so inform the Medical Examining Board at 1400 East Washington Avenue, Madison, Wisconsin 53702. ■

Governmental Affairs rejects latest nurse-midwife bill

The Commission on Governmental Affairs in January rejected a substitute amendment to Assembly Bill 66 which would establish a nurse-midwife program in Wisconsin. The Commission directed SMS staff to draft a substitute amendment to be introduced at the request of the Society, which would provide that the practice of nurse-midwifery in Wisconsin: (1) occur under the supervision of a physician; (2) occur within a written contractural agreement between a physician and the nurse-midwife; and (3) be defined as "perinatal care" within a hospital setting.

In other action, the Commission:

- Directed an ad hoc committee composed of Carl Eisenberg, MD, Milwaukee; Michael Mehr, MD, Marshfield; and Kenneth Dempsey, MD, Menomonee Falls, to look into the issue of independent prescribing of drugs by physicians' assistants and to make appropriate recommendations to the Medical Examining Board. They informed the Board in late January that the Society was "categorically opposed to any relaxation of the present prohibitions on independent prescribing or dispensing of any drugs by any physician assistants." They called for an immediate study of the legitimacy of current prescribing patterns of physicians in relation to allied health practitioners.

- Opposed two bills which would alter the membership of the Medical Examining Board. One bill, AB 1070, would decrease the total membership of the Board from nine to seven members, with four professional members and three public members. AB 1100 would place public member majorities on all examining boards regulating health professions. The Commission, while it was not opposed to increasing public members on the Board, stipulated that professional members should maintain the majority.

- Opposed a bill expanding the definition of practitioner under the Control Substances Act to include persons licensed to prescribe in other states. This would allow Wisconsin pharmacies to honor prescriptions for controlled substances written by out-of-state physicians. The Commission opposed the legislation because it would weaken already difficult efforts to monitor, control, and enforce the provision of the Controlled Substances Act. ■

Assembly committee rejects Insurance Commissioner's rules

An Assembly committee has voted 9-1 to reject an administrative rule being proposed by the State Insurance Commissioner which would impose an actuarial accounting system for the Patient Compensation Fund in Wisconsin.

The proposed rule would also require that the Fund reserve monies for incurred but not reported claims (IBNRs). The Assembly Financial Institutions Committee made its decision following a public hearing at which SMS Physicians Alliance Director Brian Jensen and SMS Legal Counsel Robert Murphy testified that the proposed rule expanded upon the statute creating the Fund and that the Fund was intended to serve as a trust fund and not an insurance corporation.

Jensen and Murphy claimed that setting aside monies for IBNRs would force placement of existing monies into reserves thus rendering the Fund insolvent. While the Society does not dispute the need for "reserving" fund monies, it feels the Commissioner's plan poses unnecessary hardships on the financial base of the Fund.

The SMS alternative would permit reserves, but avoid implementation of "caps" on awards due and significantly higher fund payments in any one year.

The rule has now been referred to the Joint Committee for the Review of Administrative Rules for a 30-day review and possibly additional hearings. SMS intends to represent an alternative to the rule to the Insurance Commissioner in light of the favorable action of the Assembly committee. The alternative, which was proposed to and rejected by the Deputy Commissioner of Insurance in early January, would:

. . . Raise the maximum fee assessment from 10% to 20% of the WHCLIP premium;

. . . Consider losses paid during the current fiscal year plus losses to be paid during the next three fiscal years (for incidents occurring in the current fiscal year) in establishing annual fee assessments;

. . . Consider investment income earned during the current fiscal year plus investment income to be earned during the next three fiscal years in establishing fee assessments;

. . . Not allow the use of IBNR reserves to create an artificial Fund deficit; and

. . . Trigger award limitations and/or deficit assessments only after the actual amount of cash in the Fund falls below statutory levels. ■

Clarification on 'super-rule' letter: Emergencies

The SMS Physicians Alliance advised all SMS members in late December of the major provisions of the soon-to-be-effective Wisconsin Medical Assistance Program 'Super-Rule.' That letter included comments regarding the ability of a noncertified physician to bill for "emergency services." This new procedure does *not* relate to emergency room treatments, only to emergencies encountered in offices, accident scenes, etc. In order to be paid for emergency room treatment on a regular basis as a result of staffing, physicians *must* be certified providers and sign the new agreement. However, because the rule is permissive on private practice, a physician may sign the agreement for treatment afforded in emergency rooms of hospitals but still restrict T-19 treatments in private practice because of patient load, etc. ■

Body orifice searches subject of AMA study

A Wisconsin resolution calling for a study of the issue of body orifices performed in conjunction with the arrest and booking of individuals was approved by the House of Delegates of the American Medical Association at its interim session in Hawaii in December. The resolution was introduced by the Wisconsin AMA Delegation at the request of SMS Jail Health Advisory Committee Chairman and AMA Alternate Delegate Warren Williamson, MD, Racine.

The Wisconsin Delegation said such a study was necessary to determine the proper role of physicians in regard to body orifice searches. Several federal agencies already require that searches of body orifices be conducted by "medical personnel" at health facilities, and the American Civil Liberties Union and American Bar Association have requested that "health professionals" and not correctional personnel perform such searches. ■

State Health Plan public hearings set for March

At its January 17-18 meeting the Health Policy Council released its 652-page draft of the 1980 State Health Plan for review and comment. Comments will be taken into account by the HPC when it votes on the final Plan at its April 24-25 meeting in Madison.

Seven public hearings will be held to solicit public comment. The schedule is as follows:

March 5: Holiday Inn, 110 E Second St, Superior.

March 6: Howard Johnsons Motor Lodge, Eau Claire and Indian Head Rooms, 809 West Clairemont Ave, Eau Claire.

March 5: Holiday Inn, 201 N 17th Ave, Wausau.

March 6: Reeve Memorial Union, UW-Oshkosh, 748 Algoma Blvd, Room 214, Oshkosh.

March 5: Northeastern Wisconsin Health Systems Agency, Rice Building, 828 Cherry St, Green Bay.

March 5: Holiday Inn—Central, Garden Terrace Room, 1926 West Wisconsin Ave, Milwaukee.

March 5: Quality Inn, 4916 East Broadway, Highways 12-18 West of I-90, Madison.

Two meeting sessions will be held at each site—2:00-5:00 and 7:00-9:00 pm.

Any person can make a brief presentation at the public hearings. Written comments are encouraged and these should be sent to: Margaret Miller and John Peters, MD, Cochairpersons, Plan Development Committee, Division of Health, Room 244, 1 West Wilson St, Madison, Wis 53702. Comments should be received no later than March 6, 1980. ■

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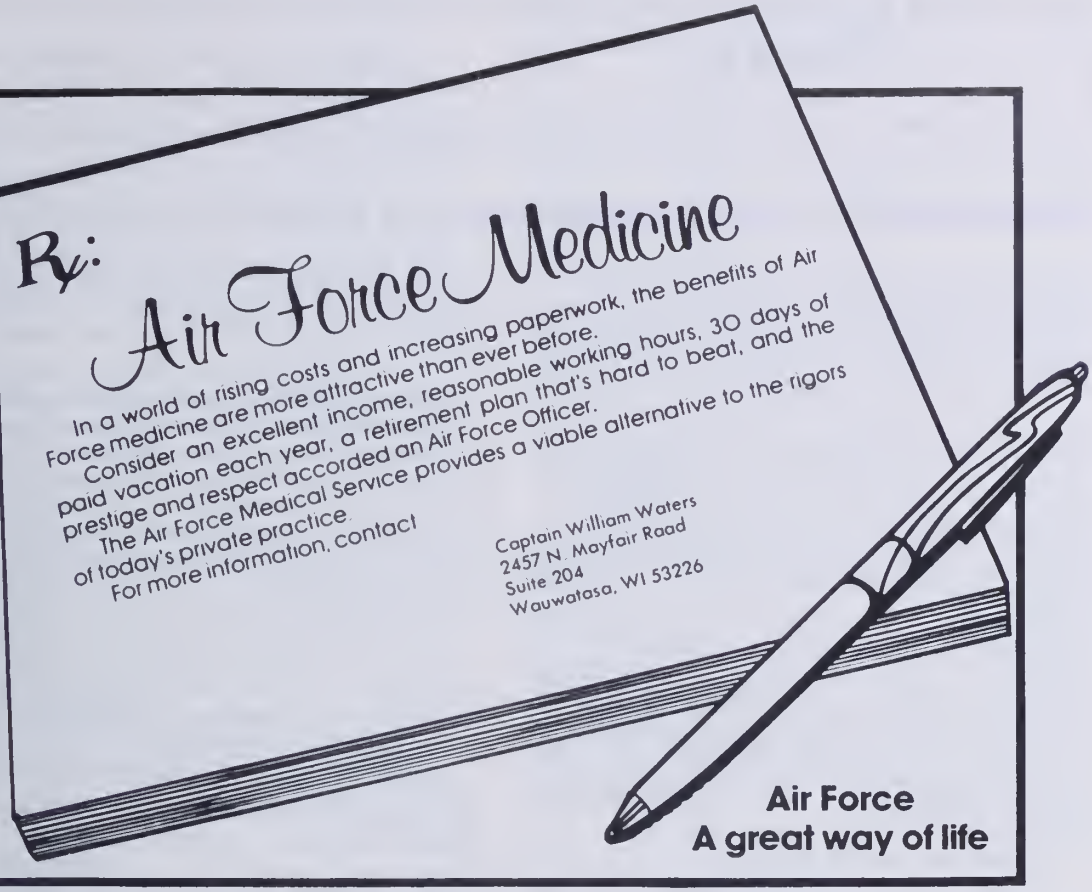

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Membership, reimbursement key issues in resolutions

The House of Delegates will consider resolutions ranging in subject matter from membership issues to physician reimbursements in government and private insurance programs at the State Medical Society's Annual Meeting in Milwaukee, March 27-29.

The following resolutions were received in the Secretary's office by the January 25 deadline. These will go to the House of Delegates for action during its three sessions at the MECCA in Milwaukee. Members are urged to express their opinions to their delegates (see page 67 for list) and to participate at the Annual Meeting Reference Committee hearings where resolutions are discussed.

Highlights of the Annual Meeting Program appeared in the January issue. Elsewhere in this issue is an official notice to members of constitutional amendments affecting unified membership which are up for vote by the House of Delegates on March 28.

(The county medical society, individual physician, or specialty section which introduced the resolution appears in parentheses.)

1. (Clark) Unified Membership

Because we need a strong political arm at the Federal level in Washington, DC, and only AMA has this capacity;

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin should not make the biggest mistake of getting away from compulsory membership with AMA."

2. (Irwin J Bruhn, MD, District 1 Councilor) Student Membership in the State Medical Society

"RESOLVED, that the State Medical Society of Wisconsin establish a 'student of medicine' section in the organization with two voting delegates from the University of Wisconsin Medical School and two voting delegates from the Medical College of Wisconsin in the House of Delegates, and that the State Medical Society of Wisconsin provide as many as possible of the services of State Medicine to student members."

3. (Joseph H Selliken, MD, Resident Physicians Section Delegates) Student Membership

"RESOLVED, that the State Medical Society create a membership classification for medical students and unlicensed postgraduate physicians; and be it further

"RESOLVED, that a nominal membership fee be established for this membership classification by the Board of Directors; and be it further

"RESOLVED, that membership benefits include receipt of basic Medical Society communications; and be it further

"RESOLVED, that the State Medical Society create a Medical Student Section with a voting delegate in the House of Delegates and an available voting position on each committee and commission of the State Medical Society."

4. (Dane) SMS Dues for Spouse Physicians

"RESOLVED, that spouse physicians (husband/wife) each shall retain membership in the State Medical Society with all rights and privileges and responsibilities, but that the total amount of annual SMS dues for such spouse physicians shall not exceed one and one-half the annual dues for an individual SMS member; and be it further

"RESOLVED, that in the event of specialty differences and ballots, each spouse physician shall receive his/her own copy of information or literature."

5. (Rusk) Annual Meeting Location

"RESOLVED, that the 1981 State Medical Society meeting be held at Telemark and that every fifth annual meeting thereafter be held in the northern part of the state."

SMS staff note: The Constitution provides that the place for holding the annual session shall be fixed by the House of Delegates, and the time shall be approved by the Council. The House has previously approved March 26-28, 1981, at MECCA-Marc Plaza in Milwaukee. Dates for 1982 through 1992 in Milwaukee, as approved by the Council, are listed in the report of the Commission on Continuing Medical Education.

6. (Clark) Compulsory Relicensure at Age 65

Because each individual's ability to function at any given age varies according to his or her individual physical and emotional condition; and no other profession requires compulsory relicensure at a specified age; therefore be it

"RESOLVED, that the requirement that physicians take a license exam after a certain age be opposed."

7. (Clark) Mandatory Continuing Education Requirements for Relicensure

Because it is highly discriminatory to insist that MDs have mandatory continuing medical education credit hours as a requirement for relicensure and no large scale studies have been done to determine the efficiency of this present law; therefore be it

"RESOLVED, that we urge that the State Medical Licensure Board should be advised to approach and evaluate alternate modes of educating the MD in deciding their competency or making them more efficient."

8. (Waukesha) Forged Prescriptions

"RESOLVED, that the State Medical Society of Wisconsin sponsor legislation calling on government

agencies to develop aggressive action against this type of activity, providing penalties for the offenders."

9. (Waukesha) Juvenile Crime Prevention

"RESOLVED, that the State Medical Society of Wisconsin serve as a catalyst, bringing together teachers, judiciary, policy personnel, legislators and other interested parties into a public forum to address itself to the question of juvenile crime prevention."

Fiscal note: Such conferences are usually designed to be self-supporting. However, the uncertainty of sufficient attendance to offset costs involves some change that a break-even point will not be achieved.

10. (Lincoln) High School Athletics

Because several coaches at the high school level are unaware of the hazards and problems associated with marked dehydration and electrolyte imbalance and are restricting water to their athletes in training; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin petition the WIAA to influence the coaches (be it high school football, cross-country, tennis, etc) to have fluid available and encourage its use without restriction."

11. (Resident Physicians Section) Smoking at SMS Meetings

"RESOLVED, that smoking be prohibited at all meetings of the State Medical Society of Wisconsin."

12. (Section on Family Physicians) Psychotherapy Services—Wisconsin Medical Assistance Program

"RESOLVED, that the following measures be recommended to all physicians in Wisconsin so that this regulation may be eliminated:

(1) The State Medical Society of Wisconsin recommends that all physicians presently providing psychotherapy continue to provide psychotherapy when indicated in the best interest of their Title XIX patients.

(2) When coding services to the Medical Assistance Program, physicians should properly code as psychotherapy those services which fit the definition and should not disguise the service as an office visit or other designation.

(3) Physicians should be instructed to report to the State Medical Society any refusal on the part of the Medical Assistance Program to reimburse non-psychiatrist physicians for psychotherapy services.

(4) The State Medical Society should, through its existing committees or by appointment of a special committee, provide a mechanism to receive these complaints and to analyze them.

(5) The State Medical Society should bring to bear its influence and financial resources to challenge this regulation in legislative committees or, if necessary, in courts of law.

13. (Oconto) Wisconsin Medical Assistance Program

Because the requirement for a physician provider agreement under the Title 19 Medicaid program effectively limits the free choice of a physician by patients under the program; and the requirement for a physician provider agreement mandates a three-way contract which is most undesirable and at least ethically questionable and creates a most unacceptable situation in which to provide medical care; and this provider agreement will be a foot in the door for such agreements to be required under the entire Medicare program, resulting in unending negotiations to eliminate such undesirable features as the failure to recognize the right of physicians to refuse to accept a given patient for care, this in turn necessitating the formation of not only one Physicians Alliance, but ten more Physicians' Alliances, with proportionate increases in Society dues; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin draft legislation to be introduced into the State Legislature which will have as its purpose the elimination of the Provider Agreements, Super Rules, etc, from the Title 19 program."

14. (Douglas) Reimbursement for Physicians' Services

Because the present method used by Medicare and Medicaid in determining "usual and customary" charges for physicians' services utilizes 13 districts in Wisconsin resulting in inequitable and unfair reimbursement between physicians who provide the same service as well as adversely affecting the recruitment and retention of physicians in the less populous areas of Wisconsin; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin use all means legally at its disposal to bring about a change at the earliest possible time in this reimbursement policy so as to authorize payment of physicians' charges under all government and private insurance programs on the basis of a single statewide area for calculating usual and customary."

15. (Barron-Washburn-Burnett) Reimbursement for Physicians' Services

"RESOLVED, that the State Medical Society of Wisconsin use all means legally at its disposal to bring about a change at the earliest possible time in this reimbursement policy (as stated above in Resolution 14) so as to authorize payment of physicians' charges under all government and private insurance programs on the basis of a single statewide area for calculating usual and customary."

16. (Pierce-St Croix County Medical Society) Physician Distribution/Reimbursement

Because one of Wisconsin's health care delivery problems is geographic distribution of physicians; and physicians in some areas in Wisconsin face an unfavorable fee structure; and loan forgiveness programs, at present, fail as an inducement to retain physicians in more remote areas because of the inequitable fee structures; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin support a policy to establish fee structures throughout the state that are equitable and foster physician distribution."

17. (Waukesha) Insurance Advisory Committees

"RESOLVED, that the State Medical Society of Wisconsin establish a dialogue with all insurance companies concerning physician fee profiles and re-establish local insurance advisory committee functions, to the extent permitted by law."

18. (Brown) Health Insurance Deductibles and Coinsurance

"RESOLVED, that the State Medical Society encourage the concept of significant deductible and coinsurance options in health insurance policies as a cost containment mechanism; and be it further

"RESOLVED, that the State Medical Society sponsored plan offer significant deductibles as an option; and be it further

"RESOLVED, that the State Medical Society undertake a program to educate its members and the general public to the economics inherent to insurance plans with significant deductible clauses and coinsurance."

19. (Pierce-St Croix) Professional Liability Insurance

"RESOLVED, that the State Medical Society seek the establishment of a separate board of directors to control and manage the Patients Compensation Fund; and be it further

"RESOLVED, that the State Medical Society take such steps as are necessary to create a physician owned and operated professional liability insurance company to work cooperatively with the Fund in the protection of physician and patient interests."

20. (Physicians Alliance Commission) Patient Compensation Panels (WHCLIP)

"RESOLVED, that the House of Delegates:

(1) Reaffirms its strong support for the Patient Compensation Panel system, a system which has demonstrated significant cost savings for the public;

(2) Encourages all members of the State Medical Society to serve on panels when called;

(3) Requests that in particular all specialty societies and sections work closely with the Physicians Alliance Commission to insure physician participation in panel proceedings and asks that all such societies and sections immediately advise their members of the importance of panel service." ■

OFFICIAL NOTICE: To members of the State Medical Society of Wisconsin Proposed constitutional amendments affecting Unified Membership rule up for vote by the House of Delegates on March 28, 1980

ARTICLE XIII of the Constitution of the State Medical Society of Wisconsin provides: "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken."

At the May 1979 Annual Meeting, two resolutions were introduced proposing amendment of Article IV of the Constitution—the socalled Unified Membership rule.

As to Resolution 1, introduced by the Council, the House accepted the report of its Reference Committee on Resolutions and Amendments to the Constitution and Bylaws "that the amendment has been introduced in timely fashion, and consistent with Article XIII of the Constitution it will lie over as presented for consideration and vote at the 1980 annual session." Resolution 1 read as follows:

> RESOLVED: That the Council of the State Medical Society of Wisconsin introduce to the 1979 House of Delegates a recommended amendment of the Constitution, pursuant to Article XIII thereof, to delete from Article IV wording which mandates membership in the American Medical Association, such Article then to read as follows:
>
> > "The Society shall consist of members who shall be the members of the component county medical societies, who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary."

As to Resolution 4, introduced by the Board of Directors of the Medical Society of Milwaukee County, the House accepted the report from the reference committee noting that the proposed amendment to Article IV "additionally strikes the clause 'who shall be members of the component medical societies.' The reference committee was not clear as to the exact intent of the amendment. The committee reports that the proposed amendment has been introduced in timely fashion, and consistent with Article XIII of the Constitution it will lie over as presented for consideration and action at the 1980 annual session." Resolution 4 read as follows:

> *Whereas,* Recent membership opinion surveys by both the State Medical Society and the Medical Society of Milwaukee County indicate that a majority of responding members are opposed to the current "unified membership" requirement contained in the State Medical Society Constitution, and
>
> *Whereas,* The Milwaukee Board of Directors is obliged to make known the wishes of its members who comprise a significant percentage of the total SMS membership, now be it therefore
>
> RESOLVED, That the House of Delegates is urged to adopt an amendment (by deletion of certain wording) in Article IV of the SMS Constitution as follows:
>
> > "This Society shall consist of members (who shall be members of the component medical societies, and who shall also be members in good standing of the American Medical Association, and) who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the Society."
>
> RESOLVED, That adoption of this amendment by the House will manifest that individual members still have a voice in determining the policies of their State Medical Society, and that their elected representatives in the House are responsive to the will of the majority. ■

(Published in the January and February 1980 issues of the *Wisconsin Medical Journal.*)

State Medical Society of Wisconsin

House of Delegates — 1980

County Medical Society	Delegate	Alternate
FIRST DISTRICT		
KENOSHA	D. N. Goldstein	L. H. Huberty
	C. E. Peterson	S. R. Rosen
	Vacancy	Vacancy
MILWAUKEE	D. S. Bruno	G. E. Auger
	P. A. Dudenhoeter	J. R. Brown
	C. P. Erwin	H. M. Cutting
	W. E. Finlayson	T. G. Dehn
	G. F. Flynn	G. J. Dorff
	H. R. Foerster, Jr	A. J. Dorrington
	J. W. Fons, Jr	K. S. Fabric
	G. H. Franke	M. T. Galang, Jr
	L. B. Glicklich	J. J. Homsey
	M. Glicklich	J. T. Hotter
	S. F. Horwitz	J. D. Hurley
	M. T. Jackels	B. W. Kennedy
	S. A. Korducki	J. M. Kenney
	P. G. LaBissoniere	T. M. Kidder
	R. E. Lauhenheimer	L. S. Larson
	R. T. Madden	D. Lepley, Jr
	J. A. Means III	D. D. Miller
	D. D. Mellencamp	S. M. Mintz
	G. L. Mendelott	D. C. Mullen
	J. P. Mullooly	W. C. Parks
	G. V. Murphy	A. E. Pohl
	A. R. Pequet	D. A. Reasa
	R. B. Pittelkow	T. A. Reminga
	S. Sakaguchi	B. B. Rhomberg
	K. E. Sauter	R. L. Ruehl
	D. P. Schlueter	R. J. Scrimenti
	K. M. Smigielski	E. P. Sinclair
	J. L. Teresi	F. H. Urban
	W. L. Treacy	W. R. Vogt
	H. F. Twelmeyer	H. M. Waldren, Jr
	H. F. Weisburg	D. M. Willson
	D. Williams	C. E. Young
	W. J. Wolosechek	F. L. Ziehl
	R. C. Zastrow	
OZAUKEE	A. L. Huckaby	J. E. Kippenhan
RACINE	E. P. Gander	H. E. Ericson
	M. G. Parker	W. J. Madden
	J. J. Veranth	C. H. Patton
	Vacancy	Vacancy
WALWORTH	E. J. Bruhn	R. S. Galgano
WASHINGTON	C. S. Geiger, Jr	W. J. Listwan
WAUKESHA	K. J. Dempsey	R. J. Darling
	T. A. Holbauer	W. B. Davies
	W. H. Konetzki	C. E. Holmburg
	G. D. Miller	M. C. Janowiak
	J. D. Riesch	M. J. Popp
	Vacancy	Vacancy
SECOND DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	R. T. Cooney	M. L. Janssen
DODGE	D. A. Buchler	C. L. Andringa
	M. A. Cunningham	J. B. Davis
	C. H. Geppert	D. S. Grah
	J. E. Gutenberger	R. W. Graehner
	F. C. Kriss	E. B. Greenberg
	J. N. Moore	W. J. Hisgen
	J. H. Morledge	R. D. Lindgren
	H. V. Moss	C. H. Mann
	C. E. Nahn	P. P. Rank
	V. W. Nordholm	P. J. Schoenheck
	S. L. Osborn	D. W. Semian
	J. K. Scott	J. M. Shannahan
	R. W. Shropshire	R. W. Shapiro
	C. A. Taylor, Jr.	J. D. Wegenke
DOUGLAS	C. W. Bush	R. F. Boock
FLORENCE	G. C. Hillery	L. E. Becher
FOND DU LAC	M. S. Blumenthal	J. E. Erlandson
JUNEAU	H. P. L. Breier	T. A. Correll
KEWAUNEE	D. E. Bates	R. R. Liebenow
LA FAYETTE	No members in county medical society	
MARINETTE	J. J. Tydrich	R. W. Edwards
OCONTO	J. Frank	R. M. Baldwin
	M. F. Purdy	A. L. Reinardy
	Vacancy	Vacancy
OZAUKEE	T. A. Galarnyk	J. A. DeGiovanni
THIRD DISTRICT		
BAYFIELD	E. M. Dessloch	Vacancy
BURNETT	V. M. Griffin	J. Strong
CHIPPEWA	J. T. Murphy	C. N. Ford, Jr
	D. L. Nelson	K. P. Grill
	K. L. Newcomer	J. M. Lockhart
	S. B. Webster	P. S. Shultz
DOUGLAS	R. R. Buan	K. M. Nararimhan
EAU CLAIRE-DUNN-PEPIN	J. H. Noble	O. M. Schneider
	R. A. Starr	T. E. Boston

County Medical Society	Delegate	Alternate
FOURTH DISTRICT		
CLARK	B. O. Gungor	R. V. Reddy
FOREST	B. S. Rathert	E. F. Castaldo
LANGLADE	J. O. Moermond, Jr	J. C. Fox
LINCOLN	J. S. Janowiak	G. C. Kloster
MARATHON	G. R. Hammes	W. G. Locher
	J. D. Kramer	T. O. Miller
	J. G. Sack	W. B. Rudy
ONEIDA-VILAS	E. N. Nevin	W. E. Raduege
PORTAGE	P. K. Hacker	B. C. Palaganas
PRICE-TAYLOR	J. R. Keuer	W. W. Meyer
WOOD	R. L. Hansen	W. J. Boulet
	M. P. Mehr	W. J. Maurer
	J. E. Thompson	J. P. Milbauer
	R. H. Ulmer	C. C. Sorensen
	Vacancy	Vacancy
FIFTH DISTRICT		
CALUMET	J. W. Knaut	J. DeArteaga
FOND DU LAC	R. S. Pelton	F. T. Santelippo
	K. A. Stormo	D. R. Weber
GREEN LAKE-WAUSHARA	J. C. Koch	A. R. Gimenez
OUTAGAMIE	J. K. Burr	C. F. Dungar
	P. M. Cunningham	J. S. Harris
	J. C. Zeiss	R. R. Kinde
WAUPACA	L. P. Maasch	D. M. Lochner
WINNEBAGO	S. A. Atassi	G. R. Anderson
	J. L. Basiliere	C. C. Baltz
	O. E. Larson	S. J. Graiewski
	J. A. Mathison	C. R. Lyons
SIXTH DISTRICT		
BROWN	G. R. Kattan	B. C. Bressler
	J. N. Lacey	R. D. Horak
	F. T. Mansell	K. R. Kuhsch
	R. L. von Heimburg	D. R. Sipes
DOOR-KEWAUNEE	J. J. Beck	W. S. Hobson
MANITOWOC	Vacancy	J. D. Lynch
	Vacancy	Vacancy
MARINETTE-FLORENCE	C. E. Koepp	J. E. Kraus
OCONTO	K. L. Strebe	J. S. Honish
SHAWANO	W. W. Grover, Jr	J. J. Albright
SHEBOYGAN	R. A. Keller	P. R. Marsho
	J. B. Kuplic	S. C. Westcott
SEVENTH DISTRICT		
BARRON-WASHBURN	D. E. Riemer	J. F. Maser
BURNETT	M. W. Asplund	R. A. Henry
CHIPPEWA		
EAU CLAIRE-DUNN-PEPIN	P. J. Happe	S. G. Brown
	K. E. Walter	G. E. Owen
	J. E. Willard	J. B. Young
PIERCE-ST. CROIX	D. M. Woeste	J. E. Powell
POLK	M. E. Wegner	J. O. Simenstad
RUSK	R. R. Johnson	R. G. Nash
EIGHTH DISTRICT		
ASHLAND-BAYFIELD		
IRON	A. A. Koeller	J. C. Oujiri
DOUGLAS	C. M. Scott	T. J. Doyle
SAWYER	M. H. Sahs	Vacancy

SPECIALTY SECTIONS

Section	Delegates	Alternates
ALLERGY & CLINICAL IMMUNOLOGY	Vacancy	M. Z. Fructman
ANESTHESIOLOGY	J. T. Small	W. J. Holtey
DERMATOLOGY	J. E. Taxman	N. R. Eskritt
EMERGENCY MEDICINE	C. R. Turner	G. L. Johnson
FAMILY PHYSICIANS	R. F. Purtell, Jr.	J. O. Grade
INTERNAL MEDICINE	A. P. Ziebart	M. J. Mally
MEDICAL FACULTIES	M. J. Ciccantelli	M. J. Javid
NEUROLOGY	M. P. McQuillen	Vacancy
NEUROSURGERY	R. L. Suechting	J. K. Peden
OBSTETRICS-GYNECOLOGY	W. E. Martens	Vacancy
OPHTHALMOLOGY	J. E. Sella	W. J. Foster
ORTHOPEDICS	P. A. Jacobs	R. P. Johnson
OTOLARYNGOLOGY	T. W. Grossman	G. M. Seager
PATHOLOGY	E. A. Burg, Jr.	R. E. Carlovsky
PEDIATRICS	R. L. Myers	W. H. Bartlett
PHYSICAL MEDICINE & REHABILITATION	W. J. LaJoie	R. M. Krout
PLASTIC SURGERY	H. J. Hoops, Jr	G. J. Korkos
PSYCHIATRY	R. W. Link	J. D. Edson
PUBLIC HEALTH & PREVENTIVE MEDICINE	R. W. Bick	P. R. Ebling
RADIOLOGY	R. C. Feulner	M. J. S. Richards
RESIDENT PHYSICIANS	J. H. Selliken	C. Counihan
SURGERY	Vacancy	L. C. Bernhardt
UROLOGY	D. B. Gute	S. W. Fine

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of December 21, 1979

NEW MEMBERS

County Medical Society

BARRON-WASHBURN-BURNETT

Eastwood, Conrad III, 1020 Lake St, Rice Lake 54868 (1948, Regular, Internal Medicine, Certified)
Lingen, Thomas A, PO Box 127, Cumberland 54829 (1950, Regular, Family Physician, Certified)
Thatcher, Gregory B, 209 Fourth Ave, West, Shell Lake 54871 (1950, Regular, Family Physician)

CHIPPEWA

Fleming, George E, 3203 Stein Blvd, Eau Claire 54701 (1944, Regular, Orthopedic Surgery, Certified)

COLUMBIA-MARQUETTE-ADAMS

Goodman, David A, FCI Hospital, Oxford 53952 (1950, Regular, General Practice/Psychiatry)
Laserna, Ramon V G, PO Box 334, Montello 53949 (1946, Regular, General Practice)

DANE

Myerowitz, P David, Div of TS & CDS, 600 Highland Ave, Madison 53792 (1947, Cardiovascular Surgery/Thoracic Surgery, Certified-GS)
Thune, Ronald G, 1311 Theresa Terr, Madison 53711 (1948, Resident, Internal Medicine)

LACROSSE

Peck, Theodore M, 1836 South Ave, LaCrosse 54601 (1947, Regular, Obstetrics and Gynecology, Certified)

MARATHON

Lee, Yu-en, 425 Pine Ridge Blvd, Wausau 54401 (1947, Regular, Neurology/Pediatrics)

MILWAUKEE

Benson, Thomas E, 2500 E Mayfair Rd, Milwaukee 53226 (1934, Regular, Allergy/Pediatrics, Certified-PD)
Bowyer, Karen I, 2388 N Lake Dr, Milwaukee 53211 (1951, Regular, Internal Medicine)
Davidoff, Donna D, 4363 W Dean, Milwaukee 53223 (1953, Resident, Physical Medicine and Rehabilitation)
Farley, George E, 2400 W Villard Ave, Milwaukee 53209 (1944, Regular, Radiology, Certified)
Quackenbush, Steven, 2931A N 50th St, Milwaukee 53210 (1951, Resident, Pathology)
Smith, Miles B, 2266 N Prospect Ave, Milwaukee 53202 (1918, Regular, General Surgery, Certified)
Spiro, Herzl R, 9191 Watertown Plank Rd, Milwaukee 53226 (1935, Regular, Psychiatry, Certified)
Steliga, Richard, 10425 W North Ave, Wauwatosa 53226 (1946, Regular, General Surgery/Cardiovascular Surgery, Certified-GS
Voct, Raymond K, 2900 W Oklahoma Ave, Milwaukee 53215 (1920, Resident, Nuclear Medicine/Pathology, Certified-PTH)

MONROE

Burrell, James E, 409 South L St, Sparta 54656 (1950, Regular, Family Physician)
Raftery, Patricia R, DO, Rte #1, Sparta 54656 (1943, Regular, Family Physician)

OZAUKEE

Hare, James W, W13 11516 North Port Washington Rd, Mequon 53092 (1946, Regular, Geriatrics, Certified)

PORTAGE

Tomczak, Mark L, 2501 Main St, Stevens Point 54481 (1950, Regular, Internal Medicine)

ROCK

Adamski, Gary B, 1905 Huebbe Parkway, Beloit 53511 (1950, Regular, Pediatrics)
Madan, Nalina, 1011 North Main St, Edgerton 53534 (1948, Regular, Pediatrics)
West, William P, 2020 E Milwaukee St, Janesville 53545 (1945, Regular, Family Physician, Certified)

SHEBOYGAN

Hancock, Curtis W, 1011 N Eighth St, Sheboygan 53081 (1946, Regular, Internal Medicine)
Harvey, Donald J, Rte #4, Sheboygan Falls 53081 (1945, Regular, Anesthesiology)
Hermann, John P, 1011 N Eighth St, Sheboygan 53081 (1947, Regular, Urology)
Hess, George L Jr, 1521 Kaufmann Ave, Sheboygan 53081 (1948, Regular, Anesthesiology)
Kerpe, Vytas K, 1226 N Eighth St, Sheboygan 53081 (1947, Regular, Internal Medicine)
Lisberg, Kenneth J, 1226 N Eighth St, Sheboygan 53081 (1946, Regular, General Surgery, Certified)
Northrup, Cole S, 1011 N Eighth St, Sheboygan 53081 (1947, Regular, Orthopedic Surgery)

WINNEBAGO

Michlowski, Thomas J, PO Box H, Winnebago 54985 (1947, Resident, Psychiatry/Neurology)
Ostrowski, David M, 411 Lincoln St, Neenah 54956 (1948, Regular, Orthopedic Surgery/General Surgery)

WOOD

Vanderspek, Hans G, 1000 N Oak Ave, Marshfield 54449 (1932, Regular, Neurological Surgery, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Horodysky, Orest R, Cleveland, OH, to 222 Colorado Ave, Frankfort, IL 60423

IOWA

Kinder, Eugene J, Spring Green, to 999 East Baseline, #1106, Tempe, AZ 85283

KENOSHA

Lawrence, Paul J, Friendship, to 302 Vallette Way, West Palm Beach, FL 33401

LACROSSE

Evans, Roger W, LaCrosse, to 925 North Emporia, Wichita, KS 67214

MILWAUKEE

Chojnacki, Michael J, Milwaukee, to 1300 Moursund, Houston, TX 77003
Fox, Milton J, Sun City, AZ, to Headquarters TAC/SGPC, Langley AFB, VA 23665
Raisinghani, Mohini, Wood, to 12320 West Ohio Ave, West Allis 53227
Weil, Harry R, Milwaukee, to 3301 Spanish Moss Terr, Lauderhill, FL 33319

RACINE

Gerol, A Yale, Flagstaff, AZ, to 3734 Seventh Ave, Kenosha 53140

ROCK

Levin, Harlan M, Janesville, to 236 South Harbor Dr, #206, Venice, FL 33595

WAUKESHA

Frank, Eugene B, Oconomowoc, to 114 Eighth St, South, Bradenton Beach, FL 33510

WINNEBAGO

Masangkay, Generoso, Winnebago, to Naval Aerospace Regional Medical Center, Pensacola, FL 32512

WOOD

Lolley, David M, Marshfield, to Trover Clinic, Clinic Drive, Madisonville, KY 42431

Watson, Linley E, Marshfield, to 2401 South 31st St, Temple, TX 76501

DEATHS

Muehlhaus, Franz R, Milwaukee County, Oct 14, 1979
MacGregor, James W, Columbia-Marquette-Adams County, Nov 1, 1979
Cinelis, Ann Adelle, Sheboygan County, Nov 8, 1979
Thomas, Lillian M, Milwaukee County, Nov 17, 1979
Rydell, William B, Barron-Washburn-Burnett County, Nov 24, 1979
Lundstrom, J H, Walworth County, Dec 5, 1979
Gorsky, Budd A, Milwaukee County, Dec 9, 1979
Kretchmar, Morris, Milwaukee County, Dec 14, 1979
Selle, Frederick S, Milwaukee County, Dec 16, 1979
Olsen, Arthur H, Milwaukee County Dec 18, 1979 ▪

Obituaries

◊ **County, State, AMA Members**

◊ **Franz R Muehlhaus, MD,** 86, Milwaukee, died Oct 14, 1979 in Milwaukee. Born Apr 1, 1893 in Germany, Doctor Muehlhaus graduated from the Universities of Leipeig and Munich in Germany in 1919. His residency was completed at University Clinics in Munich. Surviving are his widow, Mary and daughter, Dr Rea Muehlhaus of Elm Grove.

George S O'Brien, MD, 53, Lake Forest, Ill, died Nov 16, 1979 in Lake Forest. Born Aug 3, 1926 in Madison, Doctor O'Brien graduated from the University of Wisconsin Medical School, Madison, in 1956 and served his internship at Vanderbilt University Hospital in Nashville, Tenn. His residency in neurology was taken at the University of Wisconsin in Madison. Doctor O'Brien was associate director of Clinical Research at Abbott Laboratories for five years and then was associated with the Veterans Administration Hospital in North Chicago. Surviving is his father, George of Menomonie.

◊ **Ann A Cinelis, MD,** 66, Sheboygan, died Nov 8, 1979 in Sheboygan. Born Jan 31, 1913 in Sheboygan, Doctor Cinelis graduated from the University of Wisconsin Medical School, Madison, in 1948 and served her internship at St Joseph's Hospital in Marshfield. She had practiced medicine in the Sheboygan area for 29 years. Surviving is a sister, Mrs. Edward Girdaukas of Sheboygan.

◊ **William B Rydell, MD,** 75, a Rice Lake physician for more than 40 years, died Nov 24, 1979 in Las Vegas, Nev. Born May 24, 1904 in Duluth, Minn, Doctor Rydell graduated from Harvard University Medical School in 1929 and began practicing in Rice Lake in 1932. He was one of the founders of the Rice Lake Clinic and continued active in its operation until its merging in 1974 with the Indianhead Clinic. Surviving are his widow; two sons, Dr William Rydell, Jr, Las Vegas and Peter of Rice Lake; and two daughters, Caroly, Wolsley, Mass, and Cynthia of Las Vegas.

◊ **Budd A Gorsky, MD,** 33, Milwaukee, died Dec 9, 1979 in Milwaukee. Born Sept 8, 1946 in Milwaukee, Doctor Gorsky graduated from the University of Wisconsin Medical School, Madison in 1973. He served his internship at Mount Sinai Medical Center, Milwaukee. Surviving are his parents, Mr and Mrs R L Gorsky of Racine.

◊ **Morris Kretchmar, MD,** 75, Milwaukee, died Dec 14, 1979 in Milwaukee. Born July 4, 1904 in Philadelphia, Pa, Doctor Kretchmar graduated from Marquette University School of Medicine in 1929 and served his internship at St Joseph's Hospital, Milwaukee. Doctor Kretchmar was affiliated with St. Michael's, St Joseph's, and Family hospitals, all of which honored him with plaques of service recognition. Surviving are his widow, Lillian; a daughter, Sallie Wichman, Fox Point, and a son, Larry Kretchmar, MD, Los Angeles, Calif, and five grandchildren.

◊ **Fred S Selle, MD,** 86, Milwaukee, died Dec 16, 1979 in Milwaukee. Born Feb 6, 1893 in Lake Crystal, Minn, Doctor Selle graduated from Marquette University School of Medicine in 1919. A general practitioner, Doctor Selle served in World War I. Surviving are his daughters, Mary, Milwaukee, Mrs Vince (Marion) Stawbridge, Lakeland, Fla, and Mrs Clarence (Lois) Jones, Ft Morgan, Colo.

◊ **Arthur H Olsen, MD,** 77, Milwaukee, died Dec 18, 1979 in Milwaukee. Born Mar 14, 1902 in Milwaukee, Doctor Olsen graduated from Marquette University School of Medicine in 1928. He served on the Police Department's Medical Panel, Milwaukee, and later as chief physician from 1941 to 1968. Doctor Olsen, a general practitioner, practiced in Milwaukee from 1926 until 1972 when he retired. He also served as chief-of-staff of St Luke's Hospital for several years. Surviving are his widow, Lynda; two sons, Jack of Roanoke, Tex, and Arthur, Milwaukee.

Ralph Milton Waters, MD, 96, Orlando, Florida, died Dec 19, 1979 in Orlando. Born Oct 9, 1883 in Ohio, Doctor Waters graduated from Western Reserve University in 1912. After a general practice in Sioux City, Iowa, and an anesthesiology practice in Kansas City, he joined the faculty of the University of Wisconsin Medical School, Madison, in February 1927. He was known as the "Architect of the Anesthesiology Program" at Wisconsin and headed the department until his resignation in 1949. An annual Ralph Waters Scholarship is awarded to a Junior UW medical student. Surviving are four children including Darwin Waters, MD of Madison.

Carlton Wirthwein, MD, 71, Shorewood, died Dec 29, 1979 in West Allis. Born Feb 20, 1908 in Milwaukee, Doctor Wirthwein graduated from Marquette University School of Medicine in 1935. He served in the United States Navy from 1942-1946 during World War II. He was a founding member of the Milwaukee Gynecological Society and was named to the American College of Surgeons in 1955. Doctor Wirthwein retired from his medical practice in 1978 due to ill health. Surviving are his widow, Elsbeth, and a daughter, Susan McGrath of Wisconsin Rapids. ▪

County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

CLARK: Six members of the Clark County Medical Society met January 10 in Loyal. Narasimhulu Neelagaru, MD* of Neillsville presented a paper on "Etiology and Pathophysiology of the Arteriosclerotic Heart Disease."—**N Neelagaru, MD,** Neillsville, Secretary

POLK: Ten doctors attended the Polk County Medical Society meeting January 17 in Balsam Lake where they heard Dr James LaFave of St Paul, Minn speak on "Bypass Surgery for Malignant Obesity." Following a request of retired doctors of the county that they be allowed to pay for their meals when attending the CMS meetings, members unanimously agreed that any retired doctor who wanted to come to the meetings could donate $10 to the PCMS for cost of meal and beverage.—**William Byrne, MD,** Amery, Secretary

RACINE: New officers of the Racine County Medical Society for the year 1980 are as follows: MDs John F Foreman,* president; Huron L Ericson,* president-elect; William H Stone,* secretary; Carroll M Martin,* treasurer; and James R Hammes,* past president, all of Racine.—**William H Stone, MD,** Racine, Secretary

SHEBOYGAN: Sheboygan County Medical Society at its Annual Meeting held in December reelected Bernard S Marsho, MD,* president. Other officers are MDs James B Kuplic,* president-elect; Donald D Ohme,* secretary-treasurer; Arvid O Ashby,* historian, and Thomas Mockert,* immediate past-president. Phillip H Walker, MD* was elected censor for a three-year term and the other censors are MDs Lloyd J Steffan* and Earl H Jochimsen.* Delegates to the State Medical Society are Doctors Kuplic and Robert A Keller.* Alternates are MDs Steven C Westcott* and Patrick Marsho.* All of the doctors are from Sheboygan.—**Donald D Ohme, MD,** Sheboygan, Secretary-Treasurer ▪

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

David Van Dyke, MD,* Viroqua, has joined the medical staff at the Crawford County Counseling Center, in Prairie du Chien. Doctor Van Dyke received his medical training in Michigan and served his residency in Oshkosh. He has been with the Viroqua Douglas Community Mental Health Clinic for two and one-half years and presently is acting Interim Director. In addition to seeing patients at the Counseling Center in Prairie du Chien, he has his medical practice in Viroqua.

Richard Clasen, MD, Port Edwards, recently became associated with the Nekoosa Medical Center. A specialist in internal medicine, Doctor Clasen graduated from the Medical College of Wisconsin, Milwaukee, and served his first-year residency at St Joseph Hospital, Milwaukee. His residency was completed at MacNeal Memorial Hospital, Berwyn, Ill.

Daniel L Jones, MD,* Eau Claire, recently was awarded a silver medal by the American Academy of Dermatology for his exhibition on micrographic surgery at the Academy's 38th Annual Meeting. Doctor Jones, a dermatologist at Midelfort Clinic, also was elected to the board of directors of the American College of Chemosurgery.

Lee A Swank, MD, Rhinelander, former chief resident of the general medicine section at the Veterans Administration Hospital, Hines, Ill, will join the Schiek Clinic in March. Doctor Swank graduated from the University of Illinois Medical School, Chicago, in 1972, and presently serves as a faculty member at the Abraham Lincoln School of Medicine at the University of Illinois.

E Lawrence Markey, MD, an orthopedic surgeon with the Winona Clinic, Winona, Minn, has joined the medical staff of St Joseph's Hospital in Arcadia. A graduate of Wayne State University School of Medicine, he served an internship at St Joseph's Hospital in Phoenix, Ariz. Doctor Markey did his residency in orthopedics at the University of Wisconsin Medical School, Madison, and was chief of orthopedics with the United States Air Force for three years.

Dorothy Zajac, MD, Sun Prairie, recently became associated with the medical staff of the Sun Prairie Clinic. A native of Mahwah, New Jersey, Doctor Zajac graduated from Creighton University Medical School in Omaha, Neb. She served her internship at Cook County Hospital, Chicago, and at the Cleveland Clinic in Ohio. Doctor Zajac earned the American Medical Association's Physicians' Recognition Award in 1978.

Arthur G Norris, MD, recently joined the medical staff of Milwaukee Psychiatric Hospital. Doctor Norris graduated from the University of Wisconsin Medical School, Madison. Prior to this appointment, he was clinical director of the Waukesha County Unified Services. He also is an assistant clinical professor in the Department of Psychiatry and Mental Health Sciences at the Medical College of Wisconsin, Milwaukee.

Frederick J Hofmeister, MD,* Wauwatosa, recently received a certificate of appreciation from Milwaukee Children's Hospital for outstanding and distinguished service as a member of the medical staff. In 1947, Doctor Hofmeister created the pediatric gynecology program which has continued since that time.

Kermit L Newcomer, MD,* LaCrosse, recently was elected to a three-year term on the Board of Trustees of the American Group Practice Association. An internist, Doctor Newcomer has been the Gundersen Clinic's delegate to AGPA since 1974. He also is a delegate from LaCrosse County Medical Society to the State Medical Society of Wisconsin, a member of the American Academy of Medical Directors, and currently serves as vice-president of the Gundersen Clinic, Ltd.

William T Read, MD, Eau Claire, recently became associated with the Department of Pediatrics at the Midelfort Clinic. Doctor Read graduated from the University of Kansas School of Medicine in 1974. He served his residency at University Hospitals, Madison, and then worked for two years as a pediatrician in Concepcion, Chile, as a Peace Corps volunteer.

Mary H Harris, MD and **Donald B Kelman, MD,** recently became associated with the Marshfield Clinic. Doctor Harris graduated from the Baylor College of Medicine, Houston, Tex, and completed an internship at Brooke Army Medical Center, San Antonio, Tex. Prior to joining the emergency department of the Clinic, she had worked as an emergency physician at Riverview Hospital, Wisconsin Rapids. Doctor Kelman graduated from the University of Saskatchewan Medical School in Canada, and completed his residency at the Mayo Clinic, Rochester, Minn. Prior to joining the Marshfield Clinic, he had practiced neurosurgery in Prince George, BC.

U Nanda Kumar, MD,* Greendale, has been conferred with fellowship status in the American College of Chest Physicians. The formal induction took place at the ACCP's 45th Annual Scientific Assembly held in Houston, Texas. ■

News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

American Association of Medical Assistants, Inc—Wisconsin Society is sponsoring a Professional Development and Advancement Seminar on Saturday, March 8, at the Sheraton Inn, Madison. This is the second of two traveling educational symposiums held annually throughout the state.

Seminar topics will include: *Women, Alcohol, and Drugs,* presented by Delores Niles, ACSW; *Microscope Terminology/Theory,* George Socha of the Davis Instrument Company; and *The Medical Assistant and Physical Fitness,* by Barbara B Schumann, YMCA Physical Fitness Instructor. CEU examinations will follow each session, for members desiring continuing education credits.

Costs of the seminar is $15 for AAMA members, $15 for students, and $30 for nonmembers, for those registering in advance, and lunch is included.

For further information contact Carol Wiesner, CMA, Educational Chairman, Route 2, Box 168B, Black Creek, Wis 54106.

Medical Society of Milwaukee County Auxiliary *will be sponsoring a rollicking musical, Babes in Arms,* on Thursday, March 27, which coincidentally is the opening day of the State Medical Society Annual Meeting in Milwaukee. Milwaukee Auxiliary members have extended a statewide invitation to join them in enjoying this timeless Rodgers and Hart hit.

There will be a Wine-tasting and Meet-the-Cast Party following the play at the historic Pabst Theater. All proceeds will go to the AMA-ERF.

To purchase tickets for the March 27 evening performance, make check payable to *Medical Auxiliary Theater Party,* and sent to: Mrs Daniel P Collins, 16035 Linnan Court, Brookfield, Wis 53005. Ticket prices: Orchestra, $7.50; Mezzanine Circle, $7.70; Mezzanine, $5.00; Lower Gallery, $5.00; and Upper Gallery, $4.00. Purchasers are asked to enclose a self-addressed stamped envelope.

Memorial Hospital, Manitowoc, recently announced new officers of its medical staff for 1980. They are MDs Patrick F Limonia,* president; Edward J Barylak,* vice-president; and Thomas Finnegan,* secretary-treasurer. Other physicians serving on the executive committee are MDs Mark A Sager,* David A Satchell and John Fodden. Doctor Limonia succeeds Terry Gueldner, MD* who had served as president of the medical staff for the past two years.

Luther Hospital, Eau Claire, has elected Bruce C Bayley, MD* as chief-of-staff for 1980. Robert M Lotz, MD* was elected vice-chief-of-staff and David J Katz* was elected secretary-treasurer. Department chairmen elected at the annual meeting were MDs Richard S Ostenso,* Department of Surgery; Joseph D Motto,* Department of Medicine; Daniel F Johnson,* Department of Obstetrics/Gynecology and Pediatrics; and Jack D Edson,* Department of Psychiatry and Neurology.

Douglas R Palmer, Appleton, was among those who received a score of 90 percent or better after taking the National Board of Medical Examiners (NBME) examination, part I. A student from St George's University School of Medicine located on the islands of Grenada and St Vincent, West Indies, was one of 175 students who took the exam. The total passing percentage of students who completed four semesters at St George's is over 80 percent. Overall, the University's scores approximately are twice the average passing percentage of other foreign medical schools. Of St George's 800 students, 100 are now in clinical training programs at 13 United States hospitals.

St Agnes Hospital, Shawano, has announced its new chief-of-staff for 1980 as Joseph Devine, MD.* Doctor Devine graduated from Marquette University School of Medicine and served his internship and residency at Milwaukee County General Hospital. He has been a member of the medical staff at St Agnes for 16 years. Elizabeth T Sanfelippo, MD,* an internist at the Fond du Lac Clinic, was elected secretary-treasurer.

St Francis Hospital, Milwaukee, has announced the election of Merlin A Kottke, MD,* a specialist in internal medicine, as its chief-of-staff. MDs Kenneth Smigielski,* a family practitioner, was elected chief-of-staff-elect, and Erskine R Tucker, a pathologist, was elected secretary-treasurer. ■

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City Health Officer for the city of Sioux Falls Health Department. Prefer a physician with family practice or comparable training and/or experience. Qualified to be licensed or licensed to practice medicine in the State of South Dakota. Starting date and salary negotiable. Contact A R. Zulk, Public Health Director, Sioux River Valley Community Health Center, Sioux Falls Health Department, 1320 South Minnesota Ave, Sioux Falls, South Dakota 57105. Area code 605/339-7098. All replies are confidential. Women and minorities are encouraged to apply. An Equal Opportunity Employer. 2/80

Emergency service physicians needed for a 24-hour emergency service in a fully accredited acute care facility located in a beautiful northeastern Wisconsin community. Your off duty time can be filled with year round recreational activities. Excellent salary, malpractice insurance paid. Other attractive fringe benefits. Interested physicians write to: C Vincent Cassiani, Executive Vice-President, Clintonville Community Hospital, 35 North Anne St, Clintonville, Wis 54929 or call collect 715/823-3121. 2-3/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Assistant medical director—Large financial services company located in medium size city in the piedmont region of the southeast—university setting, offering cultural environment usually found in larger population areas. Accredited medical college graduate, internship and license in good standing; prefer internist with insurance background. Reply in confidence, including salary expectations to Dept 477 in care of the Journal. 2/80

Physician wanted to join group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Marie Olson, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tfn/78

Family practitioners: To expand central core of primary care physicians in well established southeastern Wisconsin multispecialty clinic. 30 miles from Milwaukee. Excellent recreation area. $45,000 first year salary, with additional incentive plan and many other fringe benefits. Excellent opportunity. Send CV to Recruitment Committee, Burlington Clinic, SC, Box 40, Burlington, Wis 53105. 2-4/80

Family or general practitioner: One or two to serve community of Omro located ten miles west of Oshkosh on Highway 21. Modern, well-equipped facility available with option to buy or lease. Financial assistance available through community organization. Vacancy created by death of community physician. Hospital located 20 minutes away. 330 beds. Practice possibilities are unlimited due to growth of community and surrounding area. Please contact: Elaine Peck, RN, 223 Jackson Ave, PO Box O, Omro, Wis 54963. Tel: 414/685-2228. g5tfn/79

Physicians Exchange

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Family physician: Appleton, Wis—to join 4 certified ABFP physicians. City of 60,000, economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact K E Buchanan, MD, 620 Longview Dr, Appleton, Wis 54911 or tel: 414/734-7144. 1-3/80

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The Nicolet Clinic, SC a progressive 33-physician multispecialty group is looking for physicians in the following areas of practice:

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Primary care internists and family practitioners wanted, board certified or eligible, for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel: 414/289-5910. 1-6/80

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Fifty-physician multispecialty clinic in west-central Wisconsin wants allergist, cardiologist (noninvasive), orthopedic surgeon, and family practitioner to do acute medicine. Also family practice openings in nearby satellite offices. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact G E Owen, MD, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5222. 2-5/80

PEDIATRICIAN—To join 5-man department in a multispecialty clinic, practicing general and consultative pediatrics. Northeastern Wisconsin community of 50,000 with referral base 100,000; excellent medical facilities; referral Intensive Care Nursery; progressive lakeside community. Contact G D Reilly, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Tel: 414/725-7071. 2-7/80

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General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

OB-GYN specialists desired. Enjoy the security of group practice with the freedom of independent practice. If you are Board certified or Board eligible in OB-GYN, we have an interesting opportunity for you. One or two specialists are needed immediately to form an independent OB-GYN practice in a very desirable Northern Wisconsin community with a drawing population of 65,000. Active practice assured. All major specialists available for consultation. Business advice, technical and legal, will be provided. Outstanding personal benefit programs available. Income potential great. Generous starting income guaranteed. A 35 million dollar hospital just opened with available office space. For further information call 715/842-3202, or write Mr Lloyd Engstrom, PO Box 1646, Wausau, Wis 54401. 10 tfn/79

General Internist with GI endoscopic interest or gastroenterologist with interest in general internal medicine. To join busy internist with interest in rheumatology. Large consulting practice in Manitowoc-Two Rivers, Wis area. Call or write to discuss salary and other details. Info; J L Stoune, MD, Medical Arts Bldg, 600 York St, Manitowoc 54220. 5tfn79

Ob-Gyn wanted—To practice in conjunction with a 4-member OB-GYN Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 471 in care of the Journal. 9tfn/79

Fifty-man multispecialty group has an immediate opening for:

- Orthopedic Surgeon
- Family Practice
- Ophthalmologist
- Psychiatrist

Excellent starting salaries with all fringe benefits. Monroe is a very stable economically-strong community of 10,000 located 45 minutes from Madison and 90 minutes from Milwaukee. If interested, please contact T E Peters, MD, The Monroe Clinic, Monroe, Wis 53566. 9-12/79, 1-2/80

Obstetrician/Gynecologists/Family Practitioners. Multispecialty group of 28 physicians is offering practice opportunity to: Obstetrician/Gynecologists to join 4-member department and Family Practitioners to join 8-member department. Attractive income offering and excellent fringe benefits; modern well-equipped clinic building and hospital medical school teaching appointment available. AAAHC accredited facility and CAP accredited laboratory. Satellite practice location also available. Excellent educational system and facilities. Recreational activities, exceptional locally, and your choice outside of area within three hours traveling. Contact J E Hartfield, MD, Medical Director, or F J Wilkus, FACMGMA, Administrator, Olmsted Medical and Surgical Group, PA, 210 9th Street, SE, Rochester, Minn 55901, or call 507/288-3443. 2-4/80

Urologist position available at progressive VA Medical Center located in Michigan's upper peninsula. Board Certified candidates are preferred. The community offers ideal family living in town of 18,000 people with good schools, year-round sportman's area with excellent hunting, fishing, and winter sports. Well equipped 214-bed GM&S medical center offering competitive salary and benefits. Applicants must meet required spoken and written English proficiency. Write: Chief-of-Staff, VA Medical Center, Iron Mountain, Mich 49802 or call: 906/774-3300, ext 227. Allowable moving expenses paid. Equal opportunity employer. 2-4/80

Neurologists: Board eligible or certified neurologists sought for practice with busy neurosurgical group. Prefer experience with EEG and EMG. Excellent starting salary and fringe benefits. Contact Dept 472 in care of the Journal. 11tfn/79

Wanted: General Surgeon needed to join group of three Board Certified Family Practitioners. Present surgeon in group retiring after 24 years of excellent established practice. Cumberland is a lovely city of 2000 surrounded by lakes. Six-man clinic adjacent to remodeled 47-bed hospital and new surgical suite. Minneapolis, St Paul, and Eau Claire each 80 miles away. Contract negotiable. Corporate member in one year. Contact D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 2-4-/80

Family practice physician wanted to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Family physician or general practitioner. Excellent opportunity for the new physician desiring a good start or the experienced physician wanting a change. Progressive community located 30 miles east of Green Bay is seeking another physician to join the Algoma Clinic. Service area of over 6,000 presently served by four very active, cooperative, talented physicians. Good hospital (JCAH) approved in town. Generous starting income guaranteed with tremendous future and income potential. Full partnership after one year if desired. Rural living with small town privacy yet close to bigger cities of Green Bay and Milwaukee. Excellent recreational area for fishing, hunting, camping, boating, sailing, cross country and downhill skiing. Fine schools, library, churches, and social organizations. We would enjoy showing you and your family what we have to offer. For further details, call collect or contact Steven H Spencer, Admin, Algoma Memorial Hospital, Algoma, Wis 54201. Tel: 414/487-5511.

CLINICAL DIRECTOR

Mellow and Medical—the best of both worlds. The medical model is alive and well in a CMHC that needs a full-time CLINICAL DIRECTOR. A scarce opportunity in a CMHC that: (a) is headed by a psychiatrist/director; (b) is part of a county comprehensive system *also* headed by a psychiatrist; (c) is in a beautiful new 6 million dollar building connected to a 250-bed general hospital; (d) is fully locally funded and not dependent on fickle Federal funds or grants; (e) has gone the "madly in all directions" route and now the board and staff are ready, under new leadership, to return to the basics of good psychiatric and mental health practice. Salary very competitive; usual benefits. Relaxed, mellow county of 85,000 looking for a solid clinician ready to practice in a friendly administrative climate. Join me in this new venture. Contact: Darold A Treffert, MD, Program Director of the Unified Board & Executive Director of the Fond du Lac County Mental Health Center, 459 E First St, Fond du Lac, Wis 54935. 2/80

Physicians Exchange

continued

Emergency Physician needed June-July 1980 to replace vacancy in five physician career oriented group at Madison, Wisconsin's largest emergency service. Great place to work and live. Send CV and will call you. John P Rahm, MD, 6105 Ridgwood Ave, Madison, Wis 53716. 3tfn/80

Family practice, OB-GYN, pediatric and internal medicine positions available with a 16-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 2-5/80

Thinking of retiring? Any age physician, medical directorships available across the USA. List valid licenses, when able to relocate. Salary $30,000/year, 35 hrs per week, malpractice insurance paid. No fee. Write: Fred Hrachovina, DO, 1000 Second Ave, South, Minneapolis, Minn 55403 or call 612/332-7938. p2/80

Medical Facilities

Space available in westwood professional building, Delafield, Wis. 2000 sq ft on ground level; design your own floor plan. Easy access to 1-94. Oconomowoc Memorial is just 10 minutes away. Negotiable lease. Call 414/276-0431 or 414/646-2340. 11tfn/79

Family practice available for one or two physicians. Thirty-year established practice of deceased physician. Excellent accredited hospital facilities located in Menomonee Falls, Wisconsin and only 10 miles from Milwaukee County Medical Complex. Area offers good schools and recreational facilities for family. Write to PO Box 307, Menomonee Falls, Wis 53051, or phone 414/251-5655. g12tfn/79

Medical office space available. Layton Medical Bldg. 2745 W Layton Ave, Milwaukee, Wis 53221. Proximity to several hospitals. 6000 sq ft and adequate parking facilities. Occupy as much space as desired. Write or call Marty Seibert, 611 North Mayfair Rd, Wauwatosa, Wis 53226. Tel 414/258-5158. 5tfn/79

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Beautiful medical building for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

Medical suites available in new medical building. Attached parking ramp. Adjacent to major hospital. For details call 414/637-5681, Racine, Wisconsin. 1tfn/80

Office space available for general or unlimited practice in Elkhorn, Wis. Contact Dept 476 in care of the Journal. 1-3/80*

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Practice available, Clive, Iowa, four miles from downtown Des Moines. Fully equipped office. Complete inventory available upon request. 850 square feet. Lease is three-year renewable. Practice comprised of cross-section in ages from infants to elderly. Receptionist and office nurse are available. Established referral patterns exist. Average income: $80,000 with flexible and minimal office schedule, no evenings or Saturdays. Practice for sale including leasehold interest, inventory and equipment, as unit. Contact Gordon E Allen, 5835 Grand ave, Suite 202, Des Moines, Iowa 50312. Tel: 515/274-3581. p2/80

Recreational

For rent: Caribbean paradise furnished two bedroom apartment near golf, private pool, beach, tennis, twenty minutes from St Thomas $300.00/week. Write: Joseph E Binard, MD, Navy Hospital, Roos Roads, Puerto Rico, FPO, Miami, Florida 34051. p12/79,1-2/80

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Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

1980 Wisconsin

MARCH 13-14: *An Update on Infectious Diseases for the Practicing Physician,* Clinical Science Center, Madison. Fee: $120.

MARCH 25: Seminar on *Interface of Staff Responsibilities and Patient's Rights,* by Robert Sadoff, MD, University of Pennsylvania. New Conference Center, Mendota Health Institute. Info: Myrna Casebolt, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704 or call 608/244-2411, ext 253.

MARCH 27-29: *4th Annual Ophthalmology Current Concepts Seminar '80,* The Concourse, Madison. Fee: $115. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

MARCH 27-29: State Medical Society of Wisconsin Annual Meeting, MECCA and Marc Plaza, Milwaukee.

MARCH 27: Wisconsin Academy of Family Physicians Board Meeting, Marc Plaza, Milwaukee.

MARCH 28: Wisconsin Neurological Society Business Meeting, MECCA, Milwaukee.

MARCH 28: State Medical Society Section on Ophthalmology Business Meeting, MECCA, Milwaukee; and Dinner, University Club.

MARCH 28: Wisconsin Society of Plastic Surgeons Annual Business Meeting, MECCA, Milwaukee.

MARCH 28: Wisconsin Society of Radiation Oncology Business Meeting, MECCA, Milwaukee.

MARCH 29: Wisconsin Allergy Society Business Meeting, MECCA, Milwaukee.

MARCH 29: State Medical Society Section and Business Meeting on Anesthesiology, MECCA, Milwaukee.

MARCH 29: Wisconsin Chapter of the American College of Emergency Physicians Business Meeting, MECCA, Milwaukee.

MARCH 29: Wisconsin Orthopaedic Society Business Meeting, MECCA, Milwaukee.

MARCH 29: Wisconsin Otolaryngological Society Business Meeting, Marc Plaza, Milwaukee.

MARCH 29: Wisconsin Society of Pathologists Business Meeting, MECCA, Milwaukee.

MARCH 29: Wisconsin Radiological Society Business Meeting, MECCA, Milwaukee.

MARCH 29: Wisconsin Surgical Society Business Meeting, MECCA, Milwaukee; and Dinner, University Club.

APRIL 17-18: *Third Annual St Mary's Symposium on Burns and Critical Care.* Presented by St Mary's Hospital Burn Center, Milwaukee. Format: Combination of didactic lectures and workshops, separate and combined sessions for nurses and physicians. Cochairmen: Burton A Waisbren, MD and George E Collentine, MD. Info: St Mary's Burn Symposium, 2323 N Lake Drive, Milwaukee, Wis 53211.

APRIL 19-20: *Therapeutics 1980,* University of Wisconsin Clinical Science Center, Madison. Fee: $110. Approved 9 credit hours in Category I for PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

APRIL 26: *Bladder Cancer Update 1980.* Twelfth Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee. See further details elsewhere in this section.

APRIL 28-30: *A Seminar-Workshop on Arthrography and Skeletal Trauma,* The Sheraton Inn, Madison. Fee: $250 seminars and workshops; $200 seminars only. 21 hours Category I of AMA, American College of Radiology applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

MAY 2-3: *Vascular Surgery Symposium,* The Wisconsin Center, Madison. Fee: $145. Approved 12 credit hours in Category I for PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

1980 Wisconsin

continued

MAY 17-18: Workshop on Practice Management, Red Carpet Inn, Milwaukee. 11½ hours AAFP and AMA Category I credit. Info: AAFP, 1740 West 92nd St, Kansas City, MO 64114.

MAY 30: *The Family in Primary Care,* Wisconsin Center, Madison. Fee: $50. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

JUNE 11-14: *Cardiac Rehabilitation: Critical Issues and Practical Concerns,* Red Carpet Inn, Milwaukee. Eligible for AMA Category I credit; UW-Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

SPRING PROFESSIONAL INSTITUTE

Presented by Psychiatry Clinic

Friday, April 18, 25, and May 2

Mount Sinai Medical Center
Milwaukee, Wisconsin

April 18: *The Behaviorally Disturbed Mentally Retarded,* presented by Bruce Bell, MS; Bella H Selan, MS; Mary K Madsen, RN, MS, Susan Barksdale, ACSW, et al

April 25: *Treating The Mentally Impaired Elderly,* presented by Barbara Silverstone, DSW, Carole Gold, MSSW, et al

May 2: *Eating Disorders—Anorexia Nervosa and Bulimarexia,* presented by Marlene Boskind White, PhD; Rita Hansen, MD; Lois Rollman, MSW et al

All workshops are geared to physicians, psychologists, nurses, and social workers involved in active treatment situations. Info: Mrs Bella H Selan, MS, Psychiatry Clinic, Mount Sinai Medical Center, PO Box 342, Milwaukee, Wis 53201. Tel: 414/289-8150.

THE NEUROBIOLOGICAL ASPECTS OF AGING

A seminar to be held in conjunction with the First Annual Meeting of the Wisconsin Association of Nursing Home Medical Directors.

March 26-27 at Pfister Hotel in Milwaukee

Nursing home leaders in medicine and nursing will be participating in the 1 1/2 day seminar being co-sponsored by the Medical College of Wisconsin, Wood Veterans Administration Medical Center, and the Marquette University College of Nursing.

Conference is open to physicians and nurse-practitioners interested in geriatrics and qualifies for 9 hours of Category I CME credit.

To register, contact: Mrs Marilyn Cheung, Office of Continuing Professional and Allied Education, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wis 53226 (Phone: 414/257-8221).

Jun 12-13: *Neurosurgical Intensive Care Symposium,* Inn On The Park, Madison. Fee: Physician, $110; Nurse, Resident, $60; Physician/Nurse Team, $140. Info: Contact Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

JUNE 19-20: *Symposium on the Diabetic Pregnancy and the Infant of the Diabetic Mother,* Wisconsin Center, Madison. Fee: $130. 12 credit hours of PRA-AMA Category I. AAFP prescribed credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

JUNE 26-28: Wisconsin Academy of Family Physicians Annual Scientific Assembly and Congress of Delegates, Chula Vista Resort, Wisconsin Dells, Wis. Info: WAFP, 850 Elm Grove Rd, Elm Grove, Wis 53122.

1980 Others

MARCH 9-15: American Society of Contemporary Ophthalmology, joint meeting with international Glaucoma Congress, Sheraton Twin Towers, Orlando, Florida. Up to 50 CME hours, Category I. Info: John Bellows, MD, ASCO, 6 North Michigan, Room 1110, Chicago, Ill 60602.

12/79,1-2/80

University of Wisconsin-Extension
Dept of Continuing Medical Education
and UW Medical School

TELEPHONE CONFERENCES—1980

Thursday, April 3, 10, 17 & 24—7:30 am

Cancer Management

April 3: Breast Cancer Management—Update, *Thomas E Davis, MD*

April 10: Interferon and other Immunomodulators in Cancer, *Ernest C Borden, MD*

April 17: Management of Colon-Rectal Cancer, *Hugh L Davis Jr, MD*

April 24: Newer Concepts in Bladder, Prostate, and Kidney Cancer, *Dennis L Citrin, MD*

Info: Nancy Vilbrandt, Dept of CME, 610 N Walnut, Madison, Wis 53705, tel: 608/263-2860.

NUCLEAR CARDIOLOGY FOR THE PRACTICING PHYSICIAN

Third Annual Symposium arranged by Dr Harold L Brooks and Dr Jagmeet S Soin at the Medical College of Wisconsin

July 27—July 30, 1980

The Hilton Head Inn at Sea Pines Plantation, Hilton Head Island, South Carolina

Course is designed to bring the state of the art in Nuclear Cardiology to the practicing physician in community hospitals throughout the nation, specifically to physicians specializing in nuclear medicine, cardiology, and residents, fellows, and technologists. Program will consist of lectures, detailed panel discussions with audience participation and on-site demonstrations of current equipment.

For information contact—

Dr Jagmeet S Soin, Division of Nuclear Medicine, Milwaukee County Medical Complex, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

MARCH 9-15: American Society of Contemporary Medicine and Surgery, 15th annual meeting, Sheraton Twin Towers, Orlando, Florida. Up to 40 CME hours, Category I: acceptable for 25 prescribed hours, AAFP. Info: John Bellows, MD, ASCMS, 6 North Michigan, Room 1110, Chicago, Ill 60602.
12/79,1-2/80

OCTOBER 9-11: *American Cancer Society National Conference, Gynecologic Cancer*—1980. Los Angeles Hilton, Los Angeles, Calif. Approved 16 hours prescribed credit AAFP and Category I of the AMA-PRA. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference—Gynecologic Cancer—1980, 777 Third Ave, New York, NY 10017.
g2/80

1980 AMA

MARCH 13-15: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Phoenix, Ariz. See details elsewhere in this section.

APRIL 17-18: AMA 33rd National Conference on Rural Health, Boston, Mass. See details elsewhere in this section.

APRIL 18-19: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Cherry Hill, New Jersey. See details elsewhere in this section.

AMA Department of Negotiations presents

SEMINARS ON KNOWLEDGE AND SKILL DEVELOPMENT IN NEGOTIATIONS

March 13-15, 1980/Phoenix, Arizona

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution.* Hyatt Regency Hotel.

April 18-19, 1980/Cherry Hill, New Jersey

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution for Hospital, HMO, Academic and Other Salaried Physicians.* Cherry Hill Holiday Inn.

September 12-13, 1980/Kansas City, Missouri

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution with Health Planning and Other Government Agencies.* Radisson-Muehlebach Hotel.

June 12-14, 1980/Burlingame, California

Advanced seminar for physician negotiators: *Dynamics of Conflict Resolution.* Burlingame Hyatt House. (near San Francisco International Airport)

As an organization accredited for continuing medical education, the AMA Council on Continuing Physician Education certifies that the continuing medical education activities designated Category I meet the criteria for Category I on an hour-for-hour basis for the Physician's Recognition Award of the American Medical Association.

For more information on above educational programs, contact **AMA Department of Negotiations, 535 North Dearborn St, Chicago, Illinois 60610, or call 312/751-6652.**

JUNE 12-14: *AMA Seminar on Knowledge and Skill Development in Negotiations.* Burlingame, Calif. See details elsewhere in this section.

SEPTEMBER 12-13: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Kansas City, Mo. See details elsewhere in this section.

Twelfth Annual

Southeastern Wisconsin Cancer Conference

BLADDER CANCER UPDATE 1980

Saturday, April 26

Pfister Hotel, Milwaukee

8:00 am - 12:30 pm

Faculty: Alan B Fidler, MD, Chairman, Planning Committee; Irving J Selikoff, MD, Mt Sinai School of Medicine, New York City; F K Mostofi, MD, Armed Forces Institute of Pathology, Washington, DC; Harry Grabstald, MD, University of Florida, Gainesville; Morris Wizenberg, MD, University Hospital and Clinics, Oklahoma City; and Mark S Soloway, MD, University of Tennessee, Memphis.

No registration fee. Preregistration reservations should be mailed to: American Cancer Society, 6401 West Capitol Drive, Milwaukee, Wis 53216.

Through cosponsorship by the Medical College of Wisconsin, three hours of AMA Category I credits can be earned through attendance. Also, three hours of Elective credit by the American Academy of Family Physicians can be obtained.

NATIONAL MEDICAL SPECIALTY SOCIETIES

1980 Meeting Dates/Sites

MAY 9-13: American College of Cardiology, Houston, Tex. Info: W D Nelligan, 9111 Old Georgetown Rd, Bethesda, MD 20014.

APRIL 14-18: American Association of Pathologists, Grand Hotel, Anaheim, Calif.

APRIL 20-25: American Occupational Medical Association, Detroit Plaza Hotel, Detroit, Mich.

APRIL 28-MAY 2: American Pediatric Society, Convention Center, San Antonio, Tex.

MAY 5-8: American College of Obstetricians and Gynecologists, New Orleans, La.

MAY 3-9: American Psychiatric Association, Hilton Hotel, San Francisco, Calif.

MAY 15-18: American Society of Internal Medicine, Hyatt Regency, Washington, DC.

MAY 18-22: American Urological Association, Hilton Hotel, San Francisco, Calif. (Annual Meeting)

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

MEDICAL BOARD CLARIFIES POLICY ON TEACHERS GIVING DRUGS. Teachers now have the legal authority to give, under proper supervision, oral medications to students, according to a recent ruling by the State Medical Examining Board. Board members agreed that dispensing oral medication is equivalent to the practice of medicine, but decided that it may fall under the area of delegated authority from a physician, as in the case, for instance, of a doctor's prescription. Board members agreed that a broader administrative rule covering teachers' medical authority is necessary. A spokesman for the Board said that ruling may cover emergency injections given by teachers to students.

SMS Assistant Secretary Bernie Maroney appeared at the hearing and expressed the Society's support of the action taken by the Board. The Society also suggested the implementation of an administrative rule clarifying that medication, both orally and by injection, can be administered by school personnel, if done so under the delegation powers of a physician with proper prescriptions and necessary protocol.

SILVER NITRATE RULE WILL NOT BE ENFORCED. The State Division of Health has decided that it will not enforce on a statewide basis a Wisconsin administrative rule (H45.25) requiring that silver nitrate be placed in the eyes of a newborn baby when tetracycline or erythromycin eyedrops or ointment is used in its place. Last December the Division of Health was ordered by the Dane County Circuit Court to stop enforcing the rule for a 30-day period. The Division has since received an extension on that court order to allow it time to propose an amendment to the Wisconsin Administrative Code. The proposed amendment would allow physicians to make a judgment on whether to use silver nitrate, tetracycline, or erythromycin. Meanwhile, public hearings on the rule change will be held in late February.

USE OF ICD-9-CM DIAGNOSIS CODE ENCOURAGED IN MEDICARE PROGRAM. The Federal Bureau of Health Care Financing has asked that physicians who use diagnostic codes use ICD-9-CM for Medicare (Title 18) claims. Physicians should note that the use of ICD-9-CM is *not* required, only encouraged. In November 1979 the State Department of Health and Social Services and EDS-Federal Corp announced that they were converting to CPT-4 procedure and ICD-9-CM diagnosis codes. It is anticipated that these codes will be *mandated* by Spring 1980 for Medicaid (Title 19) claims in Wisconsin. Copies of the CPT-4 guide, at a cost of $12.00 per copy, may be ordered from: Order Dept, OP-41, AMA, PO Box 821, Monroe, Wisconsin 53566. The ICD-9-CM guide may be ordered from the American Hospital Association, Attn: Order Dept, 840 North Lakeshore Drive, Chicago, Illinois 60611. The cost of the three volume ICD-9-CM set is $49.50, but any single volume can be purchased for $19.50. EDS-Federal recommends volume two as being most helpful for physicians. ■

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WISCONSIN MEDICAL JOURNAL

MARCH 1980

• The unimpaired physician/President Treffert • The tie breaker (third opinion?) • Doctors afield in early Wisconsin/Doctor Connors • Perspectives on adolescent pregnancy/Doctor Schwartz • Pregnancy out of wedlock—a growing problem/Doctor Pawset • Wisconsin running weekend April 11-12

Now, two dosage forms

Nalfon®
fenoprofen calcium

300-mg.* Pulvules® and 600-mg.* Tablets

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Division of Eli Lilly and Company
Indianapolis, Indiana 46206

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*Present as 345.9 mg. and 691.8 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. and 600 mg. fenoprofen respectively.

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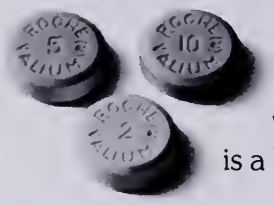
A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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President's Page

Darold A Treffert, MD

The unimpaired physician

This past year I have had the privilege, on these pages, to write about our profession, our patients, our politics, our problems, and our possibilities. In this my final President's Page I would like to write about physicians, about us. Not what we do, but what we are. Noble and important as it is to identify and help the impaired physician, what can we do to keep unimpaired physicians—ourselves—just that way—unimpaired? What "physician heal thyself" advice is there, if any, to allow the practice of medicine to be a part of a meaningful life, but not provide the only meaning to life? What can we do to strike a sensible balance between what we do with the equally important opportunity, and one of the really neat things about the planet, of getting to know, appreciate, and value the persons we are privileged to live with and love?

Being a doctor, I'd like to write a prescription for keeping us unimpaired; a prescription for something I call Mellowing. I prefer the term mellowing to coping because coping implies just hanging on by one's fingernails, just barely makeing it. That's an exhausting venture. Maturing, which means "fully developed and ripe," sounds a bit better than coping until one realizes that being mature is also to be "ready for reaping or gathering" and, in medical terms, means "about to develop pus." None of us likes to think of ourselves as ready for reaping or gathering or about to develop pus. So I prefer the term Mellowing. Mellow means "fully developed, sweet, gentle; not course or rough; full, rich, pure; free of harshness, garishness, courseness, roughness, stridency and the rashness of youth; having attained gentleness, softness, and kindliness through aging and experience; relaxed and at ease; pleasantly convivial."

That's more like it! John Farrar, in a song "Have you never been Mellow," popularized by Olivia-Newton John, said it this way:

There was a time when I was in a hurry, as you are, I was like you.
There was a day when I had to tell my point of view.
I was like you.
Now I don't mean to make you frown,
No, I just want you to slow down.

Have you never been mellow?
Have you never tried to find a comfort from inside you?
Have you never been happy just to hear your song?
Have you never let someone else be strong?

Running around, as you do, with your head up in the clouds. I was like you.
Never had time to lay back, kick your shoes off, close your eyes. I was like you.
Now you're not hard to understand.
You need someone to take your hand.

Have you never been mellow?
Have you never tried to find a comfort from inside you?
Have you never been happy just to hear your song?
Have you never let someone else be strong?

There are a number of ingredients to Mellowing. The first is making a distinction between what one is and what one does. Not that what one does is unimportant; it simply is not all important. If I take away the things that I *do,* that which is left is what I *am.* If you take away the thing that you do, or the things that your spouse or children *do* or don't do, that which is left is what you *are* and what they *are.* How I feel about, or sense, or value the I AM part of me—self-esteem—has a great deal to do with comfortableness, adequacy, and serenity. How you feel about the I AM part of you has a great deal to do with your comfortableness, adequacy, and serenity. Self-esteem is the bottom line of mental health and it is instilled by loving and being loved and by caring and being unapathetic to each other. Rollo May said it best in his book, *Love and Will,* when he pointed out that "the opposite of love is not hate, the opposite of love is apathy." Or perhaps a little eight-year-old patient of mine said it even better when I

asked him what a nervous breakdown, which he said he had, was: "A nervous breakdown is when nobody loves you," he replied.

The second ingredient in Mellowing is other esteem—a warm, human relationship here on the planet with another Earth dweller—another Tellurian—with whom one can be honest without paying a penalty for being honest; even though that person knows the worst thing about you, he or she still thinks you're OK. It's the old hymn "Just as I am without one plea" here on the planet with another Tellurian. It's not just loving your spouse, but being in love as well.

The third ingredient in Mellowing is something I call priorities—the ability to separate urgent things from important things. Our lives are full of urgent things—telephones, on-call, waiting rooms, surgery schedules, and cardiac arrests. So full, often, that we overlook the important things in our lives—the people we are privileged to live with and love. Why is it that friendship and family, like sleep and health, so often have to be interrupted before they can be truly appreciated?

Purpose—belonging to something larger than oneself that is worthwhile—is another essential ingredient in Mellowing. I cannot prescribe purpose for others, but I can respect in them; and acknowledge in myself, a search for something that is bigger than myself or themselves—be that God, Peace, a Medical Mission, or Ecology.

Certainly the prescription would have to include the ability to relax, to "lay back, kick your shoes off, close your eyes" as the song "Have you never been Mellow" suggests. And it would include as well problem ownership—the capacity to own and solve one's own problems rather than owning and solving everyone else's problems, but not one's own. Somehow, concerning problems, we need to learn two things: (a) mental health is not the absence of problems but rather the capacity to solve them; and (b) what separates mentally healthy persons from the unhealthy is not the problems they have, but rather the solutions they use. In life, like in cards, one can be dealt some very unfair hands. I see that unfairness as I make my rounds in the hospital each day. But where did we get the idea that life, or cards, was always fair?

The ability to make choices and live with those choices is also a part of Mellowing. There is the story about the donkey who starved to death between two haystacks because it couldn't decide from which one to eat. I see people regularly who are starving to death, in psychological terms, because they cannot make a choice between vocations, living locations, whether to stay married, proceed with a divorce, advance professionally or be satisfied with where they are in the organization. Simply put, one cannot have it both ways. Choice means the capacity to make decisions and, then, the courage to live with bad decisions as well as good decisions.

Certainly perspective is an important part of Mellowing. Perspective, to me, is what a patient of mine defined as "that's as good as it gets." "That's as good as it gets" may be coming home after being away, walking by the creek with the new smell of Spring, holding hands, a warm feeling in the pit of the stomach, watching someone recover from surgery when you weren't sure they would, or hearing your son say "I know" when you tell him he's neat, he's special, he counts, and he's one of the neatest people on the whole planet. Perspective is raising profound questions like: is the jingle in the pocket worth the jangle in the head? Perspective is not just *counting* our blessing—that is, the people we are privileged to live with and to love—but loving them, holding them, caring about them and, if we do think they are special, and neat, and that they count, telling that out loud.

In my inaugural address one year ago I advised that each of us, as doctors, read *Many Moons* by James Thurber because it was the best book on diagnosis ever written—asking and listening to the patient as the first source of diagnosis and treatment suggestions. Some former patients of mine, at the Tellurian Community at Winnebago Mental Health Institute, gave me some insight into drug abuse and, from that seemingly unlikely source, came some insight and suggestions for us as well. Their prescription for themselves can be applied to ourselves:

> "The cure for drug abuse is a meaningful life. But the creation of a meaningful life is a goal for all of us, whether we abuse drugs or not. We assume it should have some of the following characteristics:
>
> It should have some warm, human relationship.
>
> It should have in it the opportunity for self-expression and honesty without penalty.
>
> It should have a sense of structure and hope for the future.
>
> It should provide a person with a sense of belonging to something larger than himself that is worthwhile.
>
> It should be a life that the individual feels he has made through his own efforts."

Or, in the words of the Fox on giving his "simple secret" to the Little Prince, "it is only with the heart that one can see rightly; what is essential is invisible to the eye."

That's Mellowing. That's what will keep us unimpaired. ■

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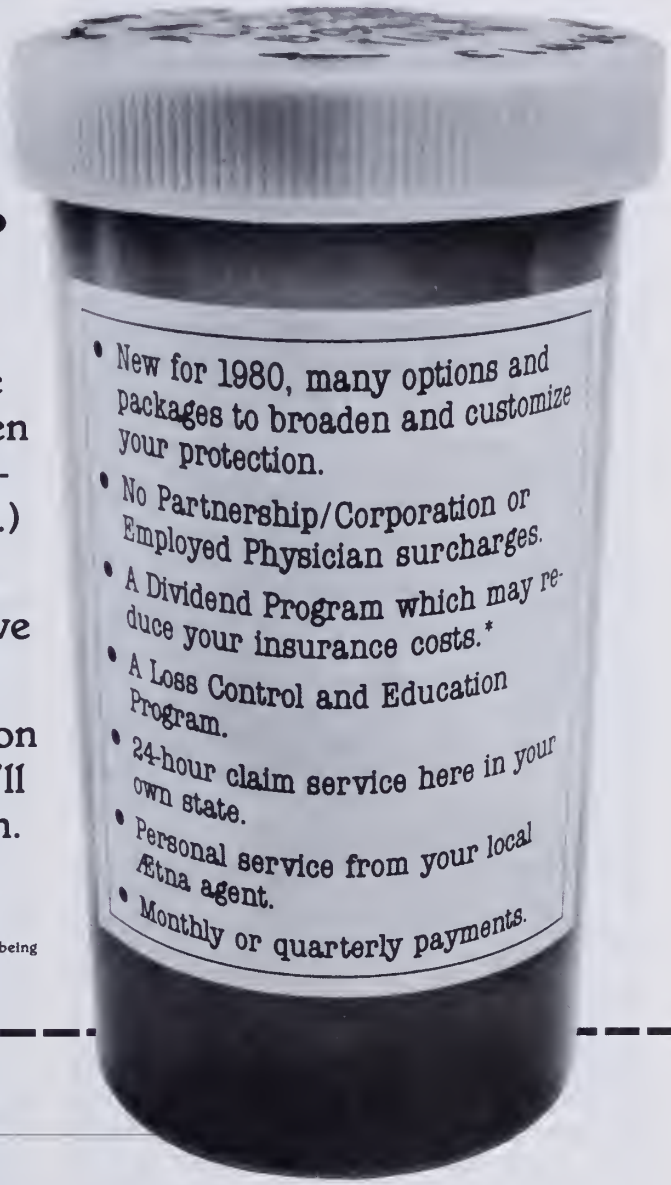

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

The tie breaker

The federal Department of Health and Social Services (the old HEW) has launched a national campaign urging patients to seek a second opinion if a surgeon recommends elective surgery. Perhaps it would have been better to continue the Department of Education in the Department of Health and Social Services as an educator would have noticed the impending dilemma occasioned by the second opinion requirement.

In any course of action, there is usually a pro and a con. If the surgeon recommends elective surgery and the physician giving the second opinion does not, this does not mean that either is correct. It means only that you have a tie. Obviously, the next recommendation from the Department of Health and Social Services will be for a third opinion or a "tie breaker" opinion.

Some surgeons may become known as "third opinion" physicians and presumably will be used only in cases of a tie between the first two. This could become a subspecialty. As with other referrals by physicians, one can choose a consultant in anticipation of how he will decide the case. In pathology, for example, it is often possible to predict that a consultant on a difficult surgical section will read it as benign while another will read it as malignant. This puts you in the position of asking a consultation from a "malignant consultant" or a "benign consultant."

This same selective use of second opinions or third opinions could be employed by the first physician which would only increase the cost of elective surgery, and the outcome could be predicted in any event.

Philosophically, many surgeons feel more aggressive in attacking chronic or disabling disease than do other nonsurgical confreres. The fact that elective surgery is not "necessary" does not mean that cancellation is wise as it may entail many other factors including quality of life, absence of pain, ability to function properly and to remain gainfully employed or be returned to work in a shorter time. Actually, all "elective" surgery is deferrable or cancelable. Witness the British experiment in socialized medicine where the wait for an "elective" herniorrhaphy may be two or three years. Hemorrhoids may be treated symptomatically with Preparation H. Uterine prolapse, cystocele or rectocele also may be dealt with with pessaries, manipulation or Tucks.

It is obvious that a tangled chain of events must occur under the new federal directives which may necessitate surgical referees, umpires or perhaps the entire NFL entourage which includes timekeepers, head linesmen and backfield judges.

—RAM

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

The end of the line

Much has been said—a great deal of it unprintable—about the manner in which relicensure based on compliance with CME requirements was handled by the State Medical Examining Board. The concensus among Wisconsin physicians is that the law is a nuisance which will do little to improve the quality of medical care.

Overlooked in the flurry of activity at year's end as the lists of noncompliers were published were the older physicians no longer actively practicing. Many had formerly kept up their licenses to retain at least a tenuous connection with their careers, mainly for documentation of status earned through years of training and dedicated service. They had no desire to maintain office practices or hospital privileges, but they would have liked to be able to write an occasional prescription and be recognized as physicians.

True, loss of license by a retired doctor isn't going to have a noticeable effect on medical manpower in Wisconsin. Probably many of them couldn't pass recertification examinations any more even if they wanted to. Certainly denial of a license is within the letter of the law when CME credits are insufficient. But one wonders whether the legislators and the Medical Examining Board ever really intended to deal so coldly with a generation of professionals who practiced in an era when so many of the aids we consider essential were nonexistent—and did so much for the citizens of Wisconsin in spite of it.

Perhaps the damage has been done. Perhaps there is no longer a way to license a Wisconsin physician who doesn't have his CME credits. But one would hope a separate category could be created, designated "retired" on the license, that would allow limited practice privileges and that would recognize past contributions. It is the sensitive thing to do.—WJB

Jonestown, Wisconsin?

Recently the Madison *Capital Times* completed a series of articles about a strange religious cult in Wisconsin. This thorough, in-depth investigation was carried out in conjunction with WISN-TV Milwaukee.

The growth of the shrine cult and the power it holds in its own geographic area should be of concern to everyone in the state. But of even greater concern to Wisconsin physicians should be the shrine's Necedah infants' home. From the description in the *Capital Times,* it certainly does not meet the usual standards for the care of pregnant women and infants. This place is called the Seven Sorrows of Our Sorrowful Mother Infants' Home, although area residents refer to it as "the baby farm."

In one instance a Wisconsin physician filed charges of infant abuse after being asked to examine an infant by prospective adoptive parents. The care recommended by the Infants' Home included dietary regimen and chiropractic treatments in Wisconsin Rapids. In lay terms "the child's head was covered with scabs and running sores, and a severe rash affected his body and torso."

On the same day as this child was born, another baby was born six weeks prematurely in the home of a Necedah family caring for the unwed mother on behalf of the Seven Sorrows. This infant was not taken to a hospital but was taken to the Infants' Home where no special equipment was available for the care of prematures. It lived only a few hours.

Medical services at the Infants' Home are directed by a specialist in psychiatry and physiatry according to the series of articles. This physician has had no special training in obstetrics or pediatrics, yet he has delivered and treated hundreds of the babies for the home. He also attends to all of the prenatal consultations. This physician is one of the "33 Chosen Ones" and a member of the corporate board of directors known as the "Inner Circle." The same physician was the one who was responsible for the care of the child with the skin problems being treated by the chiropractor, and who had ordered the premature infant taken to the Infants' Home.

This same physician attempted to perform a routine circumcision on an infant he had just delivered and accidently cut off the tip of the baby's penis. The child was rushed to a Milwaukee hospital for emergency treatment by a urologist and later had to have reconstructive surgery.

Record keeping at the home is reported to be inadequate to nonexistent, and ordinary routine prenatal care apparently is close to neglected.

Since the Infants' Home also acts as an adoptive agency, it should be under close scrutiny and control of some state agency. Certainly the State Medical Examining Board should take a long, hard look at the medical care administered in this cult-operated institution. It appears that the cult leaders exert a tremendous influence on their followers and that it has had a considerable impact on the lives of the people living in the same area.

The *Capital Times* is to be congratulated on its study and for reminding people of Wisconsin that Jonestown may not be limited to Guyana.—VSF

Frustration

Since the *Journal* is a monthly publication, it is difficult to write editorials involving current problems before they become obsolete.

The situation at the Seven Sorrows infants' home is an example. After the *Capital Times* published its series of articles, Governor Dreyfus and several legislators called on the State Department of Health and Social Services to investigate the reported irregularities.

HSS lawyers maintain that the state's access to records at the home may be blocked by last year's "privilege" legislation. Legislators insist that the legislation is certainly not meant to reduce the ability of state officials to investigate children's agencies which it supposedly controls.

By all means the Legislature should review state laws dealing with child welfare agencies, and rapidly implement legislation necessary to control such agencies in Wisconsin. And physicians in the state should lend their support to this.—VSF■

Letters

Thank you, Doctor Treffert

May I just express the appreciation of one Society member who enjoyed thoroughly Doctor Treffert's article, "Wellness . . . in perspective," in the September 1979 issue of the *Wisconsin Medical Journal.*

It was most refreshing to enjoy his good advice and common sense, written in a style both literate and "down home." And my special thanks to Doctor Treffert for the effort he puts forth in his editorial responsibilities and more importantly his service to his fellow physicians and the citizens of Wisconsin as President of the State Medical Society of Wisconsin.

—**Reed C Andrew, MD**
Green Bay, Wisconsin

Alzheimer's disease

The diagnosis of Alzheimer's disease is not widely appreciated. Many patients' families and most physicians are not aware of its importance. Doctor Fisk's recent article,[1] excludes some significant information which is helpful in the understanding of this condition. It is not necessary to separate symptoms into intellectual psychiatric and neurologic features as all symptoms are related to the primary organic changes in the brain. The symptoms are those of brain failure and concern failure of higher cortical function including speech, judgment, memory, and orientation. No single neuropsychologic or laboratory test can make the diagnosis. Doctor Fisk mentioned that no IQ or CT scan is specific. He fails to mention that the CT scan is of limited value in this condition. The use of the CT in dementia has been commented on by Kaszniak, et al,[2,3] and they have nicely demonstrated that "EEG slowing is the strongest and most general pathologic influence on cognition in elderly persons without overt brain disease." These authors found no significant relationship between diffuse EEG slowing and CT measures of cerebral atrophy. EEG slowing was associated more with a wider degree of decreased cognitive functions than atrophy and is more predictive of mortality than is atrophy. The emphasis of the CT scan in dementia has been overrated as the experience in Marshfield can testify. The CT is helpful in excluding tumors and subdurals, but the presence of atrophy in most instances does not correlate significantly with intellectual decline.

Doctor Fisk's statements concerning the course of Alzheimer's disease are misleading. I am not sure where he obtains the information that the average age of onset of senile dementia, Alzheimer type, is 74 years with a life expectancy of 5.1 years, because this certainly skews the figures provided by other people with experience in this area. The usual age of onset of Alzheimer's disease is 45 to 60 years. At the upper age range the delineation from the so-called senile dementia is blurred. In the traditional thinking, a distinction had been made between dementias occurring before age 65 and after 65. However, most authors publishing in the last three to four years tend to look at Alzheimer's disease as a continuum of presentations which extends into the population over age 65. The article quoted by Doctor Tomlinson[4] reports on only 50 patients. This number is obviously too small to determine any significant information. Doctor Fisk does not mention the work done by Wells[5] on dementia but this monograph has become a standard in the neurologic literature. A careful reading of Wells would allow a more complete listing of treatable causes of dementia as electrolyte abnormalities, infectious processes, and dementia of cardiac origin are excluded in Doctor Fisk's paper. Wells reports a treatable cause in 10 to 15 percent of the population (not 4 percent as cited by Doctor Fisk based on Tomlinson[4]) presenting with dementia.

While psychotropic agents may produce senile dementia, other medications including hypnotics and sedatives are also frequently important. The use of L-dopa in the Parkinsonian patient does not produce dementia as suggested by Doctor Fisk. The prevalence of dementia in Parkinson's disease is high. When studied by psychological methods, intellectual impairment can be demonstrated in many patients with Parkinson's disease and in some cases intellectual function can be improved with appropriate amounts of L-dopa. When the dementia has progressed significantly, L-dopa and other medications including the anticholinergics and Symmetrel® may result in an altered thinking pattern and aggravation of the preexisting dementia.

Biochemical studies of the neurotransmitters have been quite helpful in obtaining some understanding of the chemistry in Alzheimer's disease. Indeed, it has been suggested that Alzheimer's disease is a condition resulting from cholinergic failure. There have been numerous reports since 1977, however, suggesting treatment with cholinergic agents using either choline,[6] lecithin,[7] or deanol.[8] Drachman's work[9,10] determining the importance of the cholinergic systems has shown that cholinergic antagonists impair certain aspects of human memory and cognitive function in a highly consistent manner, and improvement subsequently is produced with cholinergic agonists. Because of the evidence that in normal aging in Alzheimer's disease there is impairment in the central cholinergic system, trials of cholinergic agonists were used by Drachman. In his preliminary studies of 13 patients and 20 controls a mild improvement trend for memory and cognitive performance was seen in the experimental group.[11] In testing demented patients, mild improvement in simple activities of daily living were observed, but no measurable benefits in memory or learning functions were noted. The patients picked for these studies, however, were severely demented at the time of the trial.[11]

Doctor Fisk's statement that there has been no marked clinical response with choline or cholinergic agents is not confirmed by a review of the literature.[7,8,11,12] It is emphasized, however, that future studies should concentrate on earlier cases and clinical staging should be agreed upon. The treatment period should be prolonged and careful thought given to the use of appropriate methods to assess changes. In my own experience, 4 of 11 patients who were evaluated at different stages in the course of their intellectual decline showed improvement. The other patients continued to show progression of their neurologic deterioration. When improvement occurred, it was dramatic in each case and in two cases patients were subsequently removed from nursing home situations and were returned to their homes.

The need for a central organization to direct research in the area of Alzheimer's disease has recently been answered. The Alzheimer's Disease Society was formed and this organization will readily make information available on this condition. The address is the Alzheimer's Disease Society, Mr Lonnie Wollin, Secretary-Treasurer, 32 Broadway, New York, New York 10004. I do agree with Doctor Fisk's statement that it is important to differentiate this illness from a treatable cause of dementia. It is also important that physicians explain to families that dementia is not usually due to hardening of the arteries and is not part of the normal aging process.

Doctor Green

Doctor Fisk

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—Phillip M Green, MD
Marshfield, Wisconsin

• • •

Dr Phillip Green's letter commenting on my recent article, "Senile Dementia, Alzheimer's Type: A Review of Present Knowledge,"[1] in the December issue of the *Wisconsin Medical Journal* requires a reply.

Although Doctor Green does not feel that it is useful to describe the symptoms of senile dementia as consisting of intellectual, psychiatric and neurological features, preferring instead to include all of them under the term "brain failure," I think it is helpful to recognize that senile dementia is a multi-faceted illness, that it is not just a disturbance in cognitive function or a psychiatric manifestation or a neurological condition, but that consideration of all these aspects go into the clinical diagnosis.

Dr Green questions the statement that the average age of onset of senile dementia, Alzheimer's type is 74 years with a life expectancy of

5.1 years. As noted in the article, this information is documented in the second reference.[2] It is also contained in an article by H A Wang.[3] It is well known that chronic dementia, excluding dementia due to cerebral vascular disease, has a bi-modal distribution with a small number of patients who have pre-senile dementia occurring between the ages 45-60 and a much larger number of patients with senile dementia, Alzheimer's type occurring between the ages of 70-90.

The incidence of treatable types of dementia varies greatly depending upon the observer and the type of patients coming to him. Although Doctor Green quotes a figure of 10-15%, my own experience indicates that the treatable cases of dementia in the elderly are few and close to the 4% figure cited. Certainly it is of major importance to recognize very treatable dementia regardless of whether the figure is 4% or 15% of the total.

The use of L-Dopa in elderly patients with Parkinson's disease without previous evidence of dementia has occasionally resulted in the symptoms of dementia. The manufacturers of L-Dopa indicate possible adverse reactions to L-Dopa are: "paranoid ideations, psychotic episodes, dementia, hallucinations, delusions, agitation and anxiety."[4]

Doctor Green criticizes my statement "there has been no marked clinical response with choline in the treatment of senile dementia." But the reference[5] he uses to support that criticism states "there are no important differences between patients that used choline and those that received placebo." Doctor Green's limited experience with choline in which four of eleven patients improved, is also compatible with that statement. We are certainly in need of more controlled clinical experiments before we can conclude that choline or any other cholinergic agent is effective in this illness. As a physician caring for a large number of such patients, I would welcome any useful medication. I am optimistic that in the future we shall have such a medication, but it is not useful at the present time to give practicing physicians and their patients false hopes.

Although Doctor Green and myself have obvious differences, I think it is important to recognize that we are both very concerned about senile dementia and are anxious that this concern and interest spread to other physicians. Therefore, even the above exchange of views may have served a worthy purpose.

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—**Albert A Fisk, MD**
Milwaukee, Wisconsin

Federal Employee Program

Wisconsin physicians continue to have questions regarding the Federal Employee Health Insurance Program, also called the Government-wide Service Benefit Plan administered by Blue Cross and Blue Shield United of Wisconsin.

Aside from the exclusion of inpatient benefits for alcoholism counseling, the major difference between the Federal Employee Program (FEP) and other insurance programs is nonpayment of hospital benefits when the services performed could reasonably have been done on an outpatient basis or at a lower level of care (nursing home, etc).

Wisconsin physicians need to: (1) familiarize themselves with the Federal Employee Program; (2) identify and label the records of those patients who are covered by FEP insurance; (3) whenever reasonable, study or treat these patients as outpatients; (4) when admitting a patient insured under FEP, tests or surgery should be scheduled to avoid wasted hospital days; (5) when a patient insured under the FEP is admitted, early discharge planning should be initiated; (6) physicians having questions regarding the Federal Employee Insurance Program administered by Blue Cross and Blue Shield United of Wisconsin should correspond with the undersigned as additional questions arise.

It is astonishing how many medical problems can be solved on an outpatient basis with a bit of ingenuity and considerable savings in healthcare dollars.

—**Nicholas L Owen, MD**
Medical Advisor
Blue Cross and Blue Shield
United of Wisconsin
Milwaukee, Wisconsin

Comment: There are those who disagree with Doctor Owen's opinion. It obviously establishes two classes of patients. He wishes to treat the federal employees health insurance plan patients as second class patients and, in my opinion, this is wrong.—RDS ■

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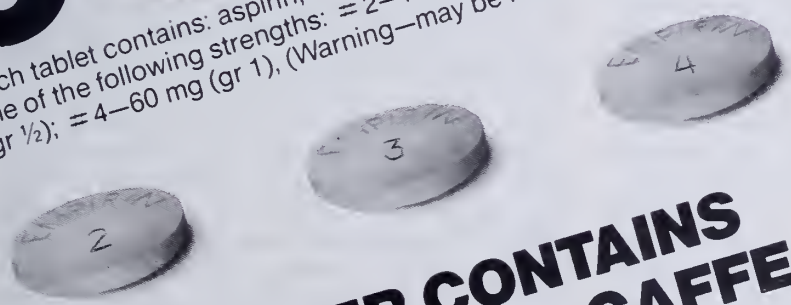

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History

Doctors afield in early Wisconsin

Dean M Connors, MD, Madison, Wisconsin

Opportunities for physicians in the first half of the eighteenth century were limited, particularly in New England. Between 1790 and 1850 there was an enormous increase in the number of physicians from 4000 to 40,000 in the United States, due largely to the proliferation of proprietary medical schools. The surplus forced some physicians to look to other kinds of work, and for the remainder, to expect limited income from a small number of patients. Even the illustrious Dr. William Beaumont found his medical practice rough going in Plattsburgh, New York. When he failed to adequately supplement his income by operating a grocery and pharmacy, he considered himself fortunate to receive an appointment in the Army Medical Corps, even though it meant posting to far-away Fort Mackinac.[1] Other physicians moved westward in an attempt to improve their financial status, but often they found themselves disappointed by the poverty of the pioneers and limited by the sparse population spread over a large geographical area. Other sources of income would thus become increasingly attractive. Some of these doctors who "went afield" in early Wisconsin made significant contributions to the growth of the State.

Among the members of the famous Cass expedition that explored the northern border of Wisconsin in 1820 was their official physician, **Dr Alexander Wolcott** (1790-1830) of Connecticut, a Yale graduate. Although Doctor Wolcott did not remain in Wisconsin after the expedition was completed, he became the Indian Agent at Fort Dearborn and one of the earliest settlers of Chicago.

Another member of the Cass expedition who saw a future in the raw lands of Wisconsin and elected to stay was James Duane Doty, later Territorial Governor and promoter of the city of Madison.[2] Doty also was interested in developing a village at the south end of Lake Winnebago, and in 1838 for that purpose he took into partnership **Dr Mason Darling** (1801-1866). The industrious Doctor Darling had completed his medical training in the Berkshire Medical Institute in 1824, and he had practiced medicine for 12 years in a small Massachusetts town. Darling also had represented his district in the Massachusetts state legislature for two terms. Ambitious and astute, Darling soon broke his business relationship with Doty and later defected from his political camp as well. In addition to his active medical practice—for a long period he was the only physician in the area—Doctor Darling operated a saw mill, ran a farm, was postmaster, road commissioner, and mayor. He represented the area in the Territorial Legislature from 1840 to 1848; and when Wisconsin became a state, he served one term in the Congress of the United States. He was one of the eight original sponsors of the Fox-Wisconsin canal project, and later he was involved in promoting the growth of railroads. He was one of the incorporators of the State Historical Society, and a founder of Lawrence College in Appleton. Doctor Darling's early vision of building a thriving city was realized beyond his greatest hopes, and he is justly remembered as one of the founding fathers of the city of Fond du Lac.[3]

When the lumberman Isaac Stephenson, later United States Senator, first visited Marinette in 1853, he could find only three houses. One of these houses belonged to **Dr Jonathan C Hall** (1809-1872), who had operated a saw mill on the Menominee River since 1843. By 1850 Doctor Hall had 50 employees in his lumbering operation, as well as extensive farm holdings. Originally prosperous, heavy competition and the economic crash of 1857 caused him to give up his lumbering business and return to the full-time practice of medicine in Marinette. One of his former employees, J J Sherman, began an apprenticeship with Doctor Hall in 1860. He attended Rush Medical School in Chicago, and returned to practice with Hall after the end of the Civil War. Dr J C Hall is remembered as one of the most respected pioneer citizens of the Marinette area,

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and a prominent contributor to the growth of Marinette County.[4]

The first large scale smelting operation in Wisconsin was that of **Dr Moses Meeker** (1790-1865) on the Blue River, near Boscobel, in 1837. Moses Meeker was born in 1790 in New Jersey where he received his academic education. Later he moved to Cincinnati where he was engaged in the manufacture of lead paints. Becoming interested in the lead mines of the Midwest, he set up the first large-scale mining and smelting operation at Galena; Illinois in 1825. When the Black Hawk war broke out in the spring of 1832, Meeker moved from Galena to Wisconsin where he continued his mining and lead processing operation, until he retired to his farm at Meeker's Grove in LaFayette County in 1854. Later he moved to Shullsburg where he died in 1865. Although exact information is lacking, Moses Meeker apparently had attended medical school in Cincinnati but never graduated. When in Galena the shortage of physicians forced him into the practice of medicine, "and for a number of years his services in this line were in very large demand, and he attained a reputation as a most skillful and successful physician." Meeker represented Iowa County in the Territorial Legislature for 1842 and for 1844, and in the first Constitutional Convention held in 1846. He was a corresponding member of the State Historical Society, and he contributed a set of personal memoirs concerning the early history of lead mining in Wisconsin. In this brief article he describes an outbreak of scurvy in Galena during a particularly harsh winter, and his use of an old Indian treatment. He wrote, "Their living had been sour flour and condemned army pork, which produced a number of cases of scurvy, and some of them quite severe; two of them had lost the use of their legs. I directed their limbs to be buried in the ground six hours a day for three days, with the use of vegetable aid externally. They recovered immediately."[5]

Politics was a major occupation in those turbulent times and then as now, physicians were not exempt. In addition to Doctor Meeker, two other physicians were elected to the first Constitutional Convention. **Dr Franz Huebschmann** (1817-1880) of Milwaukee was born in Weimar in 1817 and migrated to the United States shortly after completing his medical training. Doctor Huebschmann was soon involved in various civil and political activities, and while a member of the Constitutional Convention took an active role in championing the constitutional guarantees for equal rights of the foreign-born. He later served three terms as a State Senator, and he helped bring an early German language newspaper to Milwaukee. At least some of Huebschmann's fame resulted from his involvement in the notorious "Partridge case." In 1853 Huebschmann received a political appointment as Superintendent of Indian Affairs for the Northern District, a post incidentally coveted by Solomon Juneau. One of Huebschmann's first duties was to recover Oakaha, a Menominee Indian boy who had been taken by the Partridges, a local white family, in the mistaken notion that he was their lost son, Caspar. Huebschmann succeeded in locating the child and returning him to Milwaukee, but the Partridges again abducted Oakaha, and despite an extensive investigation by Pinkerton detectives from Chicago, disappeared permanently.[6] In its day the Partridge case attracted great national interest sparked by extensive newspaper coverage. Politicians expressed various opinions as to the morality of the issues; and a number of literary efforts, romantically describing the plight of Oakaha and his grieving mother, were published. Huebschmann himself survived the Partridge affair, held a commission as surgeon in the Civil War, and continued to play an important part in the political, medical, and social affairs of Milwaukee and Wisconsin until his death in 1880.[7]

The third physician member of the First Constitutional Convention was **Dr Stoddard Judd** (1797-1873), who represented Dodge County. Doctor Judd had previous experience as a legislator while a resident of New York state. After coming to Wisconsin in 1841, he was appointed to the office of the Green Bay land district. In 1845 he moved to Fox Lake where he became involved in railroad organization, and he was elected to both the first and second Constitutional Conventions, developing some reputation for his interest in matters of finance, taxation, and public debt.

After the voters of Wisconsin rejected the first draft of the Constitution, it was thought that by having a smaller committee, the efforts of the second convention might have better success. Therefore, the number of representatives was reduced from 125 to 69. Five of these were physicians. In addition to Doctor Judd, **Dr Samuel McClellan** (1806-1890), originally from Massachusetts, represented Racine County and served on the committee of the judiciary. After the acceptance of the revised Constitution by the people of Wisconsin, Doctor McClellan continued his interest in politics, was involved in various agricultural pursuits, operated a large farm in Kenosha County, and had an active medical practice in Kenosha. **Dr William H Fox** (1814-1883) was born in Ireland, and after completing his medical education he emigrated to the United States, first settling in Ohio, then Indiana, and finally ending up at a farm just north of Oregon in Dane County. Throughout his long life, Doctor Fox continued to practice both medicine and progressive agriculture. His involvement in politics was limited to his election to the Second Con-

stitutional Convention; he was however, a staunch supporter of the suffrage clause of the Constitution, and was said to have written the language eventually incorporated into the final form of the document. **Dr Ezra Mulford** represented Walworth County, but his contribution was comparatively limited, and his public activity was confined to this one event. The fifth physician was **Dr Albert Castleman** (1807-1877) from Milwaukee. Doctor Castleman was a prominent early Wisconsin physician, a University Regent, President of the State Medical Society (1850, 1851 and 1855) and author of a personal narrative of the Civil War published as "The Army of the Potomac, Behind the Scenes" in 1863. The book was unique in its frank criticism of some of the Union officers, and particularly the medical treatment of the sick and wounded. "The Army of the Potomac" is still readable, and continues to enjoy a reputation as a highly desirable item among collectors of rare and unusual books about the Civil War.[8]

Much of the early geological exploration of Wisconsin was done by men with medical training. **Dr David Dale Owen** (1807-1860) completed his medical education at Ohio Medical College in Cincinnati in 1836, but his first love was geology. In 1839 he was appointed official government geologist and assigned to survey the lead region of Wisconsin, Iowa, and Illinois. With a staff of 140 men he explored and mapped 11,000 square miles, making his first report in 1840. In 1848 he reported his findings on the Chippewa region of Wisconsin, and in 1852 he published a final document summarizing the geology of nearly 200,000 square miles in Wisconsin, Iowa, and Minnesota. Owen's observations formed the basis of all other subsequent explorations, and most of his conclusions are still valid. One of Owen's chief assistants was **Dr John Locke** (1792-1856) from Ohio. Doctor Locke obtained his MD degree from Yale University in 1818. When his practice was not successful, he became a teacher and geologist. In addition to his writing a portion of the 1840 report, Doctor Locke was intensely interested in the effigy mounds of Wisconsin. He was among the first to describe and picture these artifacts, identifying them clearly as being of aboriginal origin.

Considered the first official State Geologist of Wisconsin, **Dr James Gates Percival** (1795-1856) is undoubtedly one of the most interesting men to have lived in Wisconsin. Doctor Percival completed his medical degree at Yale in 1820. Despite the advantages of a physician father, he was never able to succeed in medical practice, although he did teach anatomy briefly at Yale and West Point. Percival was a man of multiple talents and great genius, but an extremely eccentric man who suffered from morbid shyness all his life. He was a gifted linguist, and worked with Noah Webster for two years on the original Webster dictionary. Percival's chief claim to fame however was as a poet. A prolific writer, his shorter poems were considered to be on a par with those of Bryant and Wordsworth, and were included in the standard anthologies of poetry well into the twentieth century. As a linguist, Percival had taught himself a large number of languages, and published poetry in several. Despite his intense literary interest, Percival saw himself primarily as a scientist, and his main interest and source of meager income was geology. In 1842 he had published the highly respected results of an extensive geological survey of his native state of Connecticut. In 1853 he was hired by the American Mining Company of New York to examine and survey their mines in Wisconsin. When it was discovered that Percival was working in Wisconsin, his reputation as a geologist was so great that a place was made for him as State Geologist. He performed two annual reports and a separate report of iron deposits in Dodge County. The second annual report, however, was delayed by his fatal illness, and the final version which included information from 38 of Wisconsin's 50 counties actually visited by him, was issued posthumously. The geological conclusions of these reports have since been amply confirmed. James Gates Percival was buried in the small cemetary in Hazel Green. Although his major contributions had been made elsewhere, he remains symbolic of the many early physicians who had significant impact on the development of this state outside the field of medicine.[9]

No one would argue that this handful of doctors had a determining impact on the fate of Wisconsin. Yet, each in his own way had an important contribution to make to an industry, a city, the exploration of the state, or in the formation of its laws. That these doctors were able to produce their achievements in the face of limited opportunities in their own chosen field should make their lives and their work doubly interesting to us.

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PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

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OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon (Dillon), R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed. New York, Raven Press, 1978, pp. 391-404.

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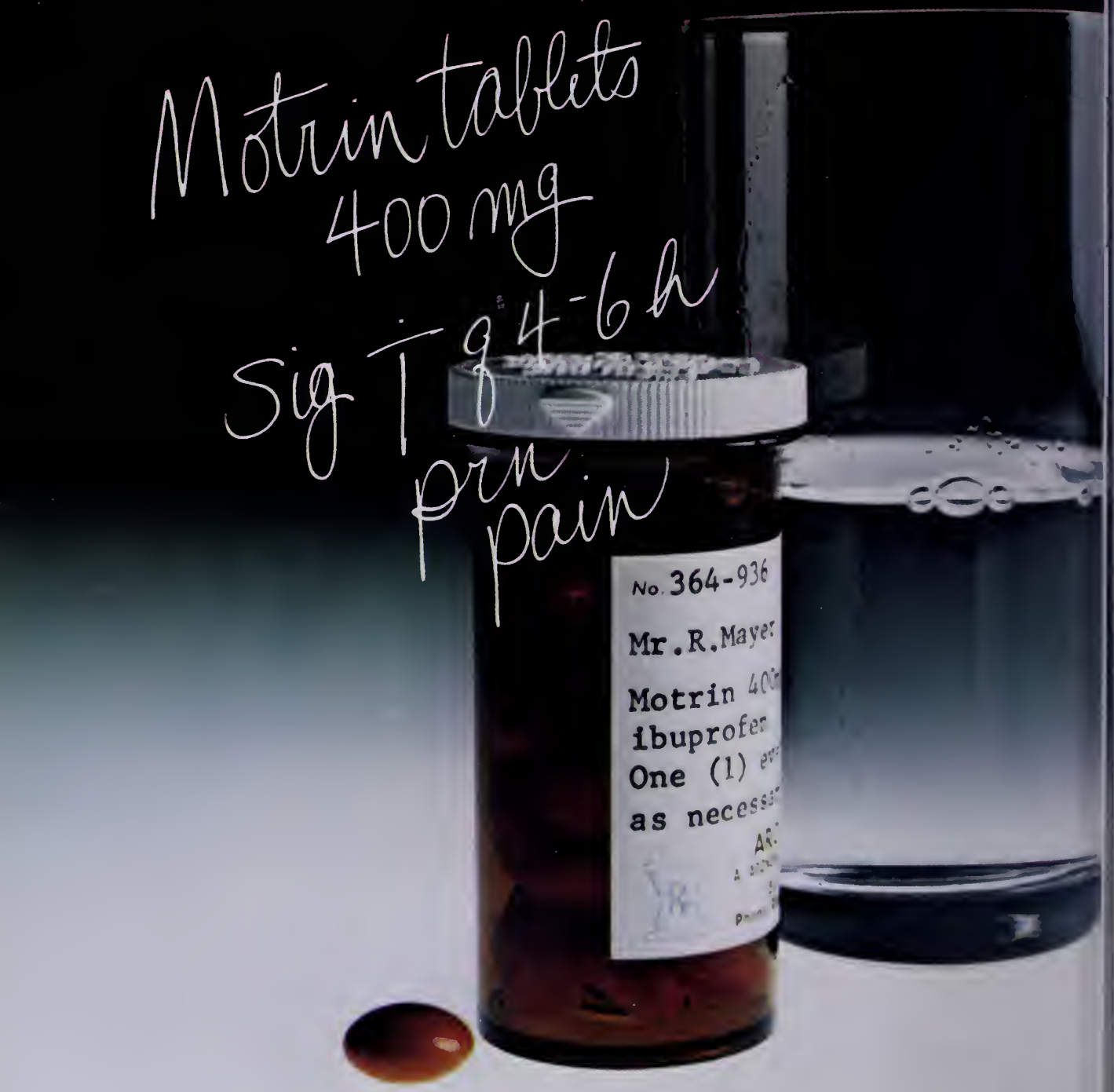

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Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

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Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

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Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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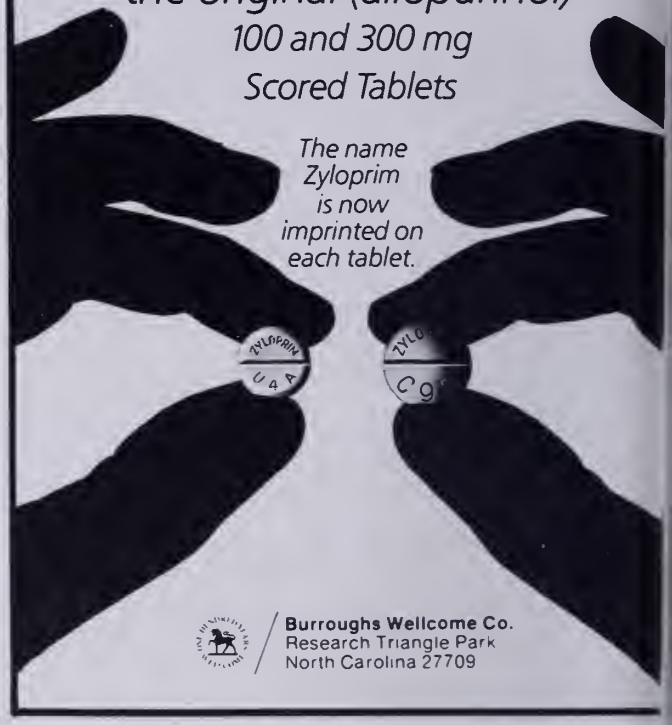

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Scientific Medicine

REFER TO—Chusid MJ, Dunigan TH, and Lewis DS: Salmonella meningitis in infancy. *Wisconsin Med J* 79:23-25 (Mar) 1980

KEY WORDS—Salmonella meningitis, antibiotic therapy with ampicillin and chloramphenicol

Salmonella meningitis in infancy

Michael J Chusid, MD; Thomas H Dunigan, MD; and **David S Lewis, MD**

Milwaukee, Wisconsin

Salmonella infection is an unusual cause of meningitis in the United States. Review of the recent literature regarding this infection in infants reveals only scattered cases, many of which were associated with high morbidity and mortality.[1-4] Two infants were recently seen at our institution with salmonella meningitis.

CASE 1. A one-month-old white female was transferred to Milwaukee Children's Hospital for management of meningitis. She had been admitted to another hospital 24 hours previously because of irritability and decreased feeding. There was no history of diarrhea or vomiting. Lumbar cerebrospinal fluid (CSF) obtained at the referring hospital contained 935 white blood cells (WBC)/μl, 94% polymorphonuclear leukocytes. CSF protein was 285 mg/dl and glucose was 0. A Gram stain revealed no micro-organisms. After a Gram-negative rod was isolated from culture of the child's CSF, she was transferred to Milwaukee Children's Hospital.

Physical examination upon admission revealed an irritable white female. Her temperature was 39.5 C. Her fontanel was full but not bulging. There was no lymphadenopathy or rash present. The remainder of the physical examination was normal except for lethargy and slight decrease in muscle tone.

From the Departments of Pediatrics, The Medical College of Wisconsin, and Milwaukee Children's Hospital, Milwaukee, Wisconsin. Reprint requests to: Michael J Chusid, MD, Dept of Pediatrics, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, Milwaukee, Wis 53233. Copyright 1980 by the State Medical Society of Wisconsin.

A WBC count was 11,200 cells/μl with 30% band forms, 13% polymorphonuclear leukocytes, 38% lymphocytes, 12% monocytes, 5% metamyelocytes, and 2% myelocytes. Her hemoglobin level was 10.8 gm/dl. Serum electrolytes and urinalysis were within normal limits.

Intravenous ampicillin (200 mg/kg per day) and gentamicin (7 mg/kg per day) were begun. On the third hospital day *Salmonella enteritidis* serotype muenchen was recovered from cultures of the patient's CSF. The organism was not recovered from the patient's stool. Ampicillin and gentamicin were discontinued and chloramphenicol (75 mg/kg per day) was begun. Repeat CSF cultures obtained 48 and 72 hours after initiation of antibiotic therapy were sterile. Approximately 80 hours after admission the patient was noted to have developed left-sided tonic/clonic seizure activity which was successfully treated with phenobarbital. At this time subdural and ventricular taps were performed. The ventricular tap was sterile but culture of the subdural fluid grew *Salmonella enteritidis*. Culture of lumbar CSF at this time remained negative. A brain scan was also negative.

Stool cultures of the family members were obtained and two siblings and the patient's mother were found to be positive for *Salmonella enteritidis* ser.muenchen.

A repeat subdural tap following 14 days of intravenous therapy was sterile. A total of 23 days of intravenous antibiotic therapy was given. Lumbar puncture and subdural taps 48 hours after the cessation of antibiotics were sterile. Two months after discharge there had been no relapse

of infection, and growth and development in this infant appeared to be normal for age.

CASE 2. A six-week-old black female was admitted to Milwaukee Children's Hospital with a three-day history of irritability and poor feeding. The child had an episode of generalized twitching and shaking on the day of admission. There was no history of vomiting or diarrhea.

Physical examination revealed an irritable infant with a temperature of 38.4 C. Her anterior fontanel was open and flat but her neck was rigid. The infant was hypertonic and there was bilateral clonus at the ankles. The rest of the physical examination was unremarkable.

On admission the patient's complete blood cell count showed 6100 WBC/μl with 45% polymorphonuclear leukocytes, 53% lymphocytes, 10% monocytes, and 2% eosinophils. Cerebrospinal fluid contained 16 RBC/μl, 5547 WBC/μl (77% polymorphonuclear leukocytes, 23% mononuclear leukocytes), a protein of 344 mg/dl and a glucose of 3 mg/dl. Ampicillin, 400 mg/kg per day and kanamycin, 16 mg/kg per day were begun. The child became afebrile within 24 hours after the inception of antibiotic therapy. *Salmonella enteritidis* was isolated from the CSF and throat cultures. Repeated stool cultures were negative for enteric pathogens. Blood and urine cultures were also negative. Kanamycin was discontinued after three days and the patient received ten days of intravenous ampicillin and four days of intramuscular ampicillin. The infant was discharged on the fifteenth hospital day without apparent residua.

Eight months later the child was readmitted to the hospital with fever, vomiting, and stupor. She exhibited left-sided hypertonicity and Cheyne-Stokes respirations. Her head circumference was greater than the 97th percentile. She developed status epilepticus and required assisted ventilation. An electroencephalogram was markedly abnormal. Long-term anticonvulsants were begun and the child was discharged after her seizures came under control. At 15 months of age the diagnosis of obstructive hydrocephalus was confirmed by pneumoencephalography and ventriculography.

The child has demonstrated marked developmental delay. She rolled over at two years of age, walked without assistance at five years of age, and is not toilet trained at six years of age. She is currently enrolled in a school for the developmentally delayed.

DISCUSSION. Central nervous system involvement in salmonellosis is unusual. In Saphra and Winter's review of 7,729 isolates of salmonellae from clinical sources, only 77 (one percent) were from cultures of spinal fluid.[5]

When salmonella central nervous system infection occurs, it occurs most often in young infants. In a study of 1,727 children less than 18 months of age with salmonellosis, 22 developed meningitis, suggesting approximately a one percent attack rate.[6] Henderson states that infants with salmonellosis less than one year of age are six times more likely to develop complicating meningitis than are older children or adults.[7]

The reason for the increased susceptibility of the infant to the development of salmonella meningitis is unknown. This, in part, may be due to immaturity in the infant's host defense mechanisms, particularly those of cell-mediated immunity and monocyte/macrophage function. Since salmonellae have the capacity to remain viable within phagocytic cells for long periods, these aspects may be particularly important in defense of the immature host against such infection.[8]

Salmonellae are isolated from clinical specimens most often in children two to six months of age.[9] The source of the organism in neonates is thought usually to be from a maternal or nosocomial source in the nursery. In older infants the source is usually a carrier who handles the child or from contaminated food.[9] Of interest in this regard was the presence of the same salmonella serotype in three of Case 1's family members.

Salmonella meningitis has prominent morbidity and mortality in infants. Henderson reported greater than 90 percent mortality in children less than six months of age who developed salmonella meningitis.[7] Mortality today appears to be substantially reduced. A number of case reports document salmonella meningitis can be cured with antibiotic therapy.[1-4] A large clinical study of salmonella meningitis from Nigeria demomstrated a direct relationship between delay of the onset of antibiotic therapy and subsequent mortality. Additionally, the younger the child at the onset of infection the worse the prognosis.[10]

Secondary neurologic complications from salmonella meningitis are commonly observed. In a recent review, West et al[3] reported 64 percent of patients with salmonella meningitis developed a relapse of meningitis, 39 percent developed ventriculitis or subdural empyema, and 43 percent developed hydrocephalus. One of our patients (Case 1) developed infected subdural effusions. Learning disability and mental retardation often occur after infection despite apparently appropriate therapy as noted in Case 2. Approximately 50 percent of survivors have no demonstrable neurologic abnormality.[3]

Successful antibiotic therapy with ampicillin, chloramphenicol, or a combination of the two has been reported.[1,2] Because of the excellent penetration of chloramphenicol into the central nervous system, even when little inflammation is present, this drug would appear to have some advan-

tages in the therapy of salmonella meningitis. Unfortunately, blood levels of this drug must be monitored in very young children to avoid serious marrow depression, and bone marrow suppression may develop after a prolonged course of therapy.

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Abstracts

Lithium carbonate-induced hypothyroidism; its many faces

JAMES W JEFFERSON, MD, University of Wisconsin Center for Health Sciences, Madison, Wis: *JAMA* 242:271-272 (July 20) 1979

Three cases of lithium-induced hypothyroidism are described to alert clinicians to diagnostic problems which might arise in patients receiving lithium carbonate for psychiatric illness. Clinical manifestations which were ultimately attributed to hypothyroidism needed to be distinguished from depression ("mediocre" mood), exacerbation of schizophrenia (visual hallucinations), and lithium-induced side effects (weight gain, hair loss). Treatment with levothyroxine led to resolution of the abnormalities and allowed the overall treatment program to proceed without interruption. ■

Porphyria turcica

DEREK J CRIPPS, MD; AYHAN GOCMEN, MD; HENRY A PETERS, MD, Univ of Wisconsin Center for Health Sciences, Madison, Wis: *Arch Dermatol* 116:46-50 (Jan) 1980

Porphyria involving more than 4,000 persons in Eastern Turkey from 1956 to 1961 was caused by ingestion of hexachlorobenzene (HCB), a fungicide added to wheat seedlings. During a site visit in 1977, thirty-two porphyric Turks (mean age, 29 years) were examined. Porphyrin concentrations were determined with samples of urine and stool from 29 porphyric and ten control Turks and compared with results from 40 subjects in the United States. Distinctive clinical features were found in porphyric subjects, including hyperpigmentation, hirsutism, severe scarring, short stature, pinched facies, small hands, painless arthritis, weakness, and enlarged thyroids. Porphyrin levels were still substantially elevated in five subjects. Hexachlorobenzene, which is fat soluble, was detected in maternal milk of one porphyric patient and in one other patient's fat. The level of HCB was not considered sufficient to account for persistence of porphyria but may be a clue to the cause of *pembe yara* (pink sore), from which many children who were breast-fed by affected mothers died with associated weakness, convulsions, and annular erythema. ■

Retention or resumption of employment after aortocoronary bypass operations

ALFRED J ANDERSON, MS; JOSEPH J BARBORIAK, ScD; RAYMOND G HOFFMANN, PhD; and DONALD C MULLEN, MD (Medical College of Wisconsin, Milwaukee, Wis; Wood Veterans Administration Center, Wood, Wis; and St Luke's Hospital, Milwaukee, Wis); *JAMA* 243:543-545 (Feb 8) 1980

Employment status and factors related to resumption of employment were studied in 564 male patients one and four years following an aortocoronary bypass operation. For age categories of less than 55, 55 to 59, and 60 years or older at the time of the operation, 90%, 68%, and 44%, respectively, remained employed four years later. Age at the time of the operation, development of angina pectoris after the operation, a previous myocardial infarction, and the physical requirements of the patient's employment were found to be related to the decision not to work years after the operation. Of patients not employed prior to the operation, 22% were employed four years later. ■

REFER TO—Kozarek JA, Starshak RJ: Ultrasonic ring sign. *Wisconsin Med J* 79:26-27 (Mar) 1980

KEY WORDS—Ultrasound, hematoma, intussusception, bowel wall

Ultrasonic ring sign

John A Kozarek, MD; Robert J Starshak, MD
Milwaukee, Wisconsin

• *The ultrasonic ring sign is a dense cluster of echoes surrounded by an echo-free mantle. It occurs in conditions which cause significant thickening of the bowel wall.*

Ultrasound examination of the gastrointestinal tract usually fails because of the total reflection of the ultrasound beam by intraluminal gas. However, there is a variety of conditions afflicting the gastrointestinal tract which can be studied with ultrasound and which have an identical ultrasonic appearance, the ring sign.

It is the purpose of this report to confirm the occurrence of this sign in two diseases of the gastrointestinal tract and to summarize those conditions which have been reported to result in this sign. The pathologic feature shared by these diseases is thickening of the bowel wall.

From the Department of Radiology; Milwaukee Children's Hospital, Milwaukee, Wisconsin. Doctor Kozarek is a Radiology Resident at University of Wisconsin Hospital and Clinics, Madison, Wisconsin. Reprint requests to: Robert J Starshak, MD, Dept of Radiology, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, PO Box 1997, Milwaukee, Wis 53201 (Phone 414/931-4160). Copyright 1980 by the State Medical Society of Wisconsin.

CASE REPORTS

Case 1. A 15-year-old girl with acute lymphocytic leukemia presented with fever and upper abdominal pain. She had diarrhea which was followed one day later by grossly bloody stools. Laboratory data showed pancytopenia with a hemoglobin level of 7.4 Gm per dl, white blood cell count 1800/mm^3, and a platelet count of 37,000/mm^3.

Abdominal ultrasound (Fig 1) revealed an echo-free tubular mass with a central core of dense echoes extending across the upper abdomen. Hemorrhage into the wall of the transverse colon was suspected and was confirmed with barium enema examination.

Case 2. A 7½-month-old female was admitted after ten hours of vomiting and intermittent episodes of crying. There was no history of fever, diarrhea, or hematochezia. Examination of the

FIGURE 1—Longitudinal ultrasonogram 1.0 cm to the right of midline displaying ultrasonic ring sign (arrowheads).

abdomen revealed a mass in the right upper quadrant. Bright red blood was found on rectal examination.

An abdominal radiograph showed an elongated mass in the right mid-abdomen. Diagnostic ultrasound (Fig 2) demonstrated an echo-free tubular structure with a central core of strong echoes in the right mid-abdomen.

A barium enema showed ileocolic intussusception which was subsequently reduced.

DISCUSSION. The ultrasonic pattern of a dense cluster of echos surrounded by an echo-free mantle was first described by Friemanis and Asher[1] in carcinomas of the gastrointestinal tract.

An identical echographic pattern, described as a "ring sign," was reported by Mascatello, et al[2] in cases of caustic gastritis, chronic granulomatous disease, lymphoma, and metastases to the stomach.

Walls[3] described six patients with pathologically proven carcinoma of the stomach who displayed the same ultrasound pattern. Lutz and Petzoldt[4] found this sign in inflammatory bowel disease and in two cases of perforated peptic ulcer. Recently case reports have appeared that describe the ring sign in pyloric stenosis,[5] intussusception,[6,7] and intramural ileal hematoma.[8] The cases reported here confirm this sign in the latter two entities.

The echo-free mantle is felt to be caused by a thickened or infiltrated bowel wall, while the central core of intense echoes is caused by the difference in acoustic impedence between the bowel wall and lumen.[4] Hence, it is understandable that this pattern can be produced by any process which causes significant thickening of the bowel wall.

We feel that the ring sign, while nonspecific, does indicate significant bowel wall thickening. Careful correlation of the ultrasonic findings with the clinical findings and other diagnostic procedures will lead to the correct diagnosis.

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FIGURE 2—Longitudinal ultrasonogram 3.0 cm to right of midline demonstrates the ultrasonic ring sign (arrows) anterior to the right kidney (K) and inferior to the liver (L).

REFER TO—Sty JR, Starshak RJ, Thorp S: The role of brain scintigraphy in metastatic Wilms' tumor. *Wisconsin Med J* 79:28-30 (Mar) 1980
KEY WORDS—Wilms' tumor, brain scintigraphy

The role of brain scintigraphy in metastatic Wilms' tumor

John R Sty, MD; Robert J Starshak, MD; and **Sharon M Thorp, RNMT**
Milwaukee, Wisconsin

• *Wilms' tumor (nephroblastoma) is the most common primary malignant tumor of childhood. The tumor frequently metastasizes, most commonly to the lungs, liver, and regional lymph nodes. The central nervous system (CNS) is a rare site of metastatic spread and is not usually included in the staging evaluation. The role of scintigraphy in Wilms' tumor metastatic to the CNS is presented.*

Wilms' tumor is a common abdominal malignancy in children. Approximately 90% of Wilms' tumors occur in children under eight years of age. The average age at presentation is about three years.[1,2] The tumor may be associated with congenital malformations.[3-6] Approximately 5% of children with Wilms' tumor have bilateral disease.[7]

Exact staging of Wilms' tumor depends upon accurate demonstration of metastatic disease. The lung is the most common site of metastasis. Approximately 10% of children with Wilms' tumor present with lung metastases.[8] The lung lesions are readily demonstrated with chest radiographs. The liver is the second most common site of metastases. Hepatic scintigraphy will accurately define the focal defects. Bone metastases are unusual[9,10] and central nervous system (CNS) metastases are rare.[11,12] Because of the rarity of metastases to these organs, bone and brain scintigraphy are not routinely performed in asymptomatic children.

This report describes abnormalities detected with radionuclide brain imaging in three children with Wilms' tumor who developed CNS symptoms subsequent to their diagnosis.

FIGURE 1A—One-hour delayed brain image. Large metastatic leptomeningeal lesion (arrow).

FIGURE 1B—Two-hour delayed brain image. Normal. Thirty months post-treatment.

CASE REPORTS

Case 1. A three-year-old female presented with a left-sided Wilms' tumor. Initial therapy consisted of nephrectomy, chemotherapy, and radiation. Following treatment she was asymptomatic for one year, at which time she developed headaches, nausea, and vomiting. Clinical examination suggested a left parietal-occipital lesion. A radionuclide brain scan using ^{99m}Tc-pertechnetate (8.3 mCi/m^2) demonstrated a large focal abnormality in the left parietal-occipital region (Fig 1A). A cerebral arteriogram demonstrated the lesion to be confined to the leptomeninges. At surgery a solitary lesion metastatic to the

From the Department of Radiology, Milwaukee Children's Hospital, Milwaukee, Wisconsin. Reprint requests to: John R Sty, MD, Dept of Radiology, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, PO Box 1997, Milwaukee, Wis 53201 (Phone 414/931-4160). Copyright 1980 by the State Medical Society of Wisconsin.

leptomeninges was removed. The child then received cranial radiation and additional chemotherapy. A radionuclide brain scan (Fig 1B) and cranial computerized tomographic (CT) scan have since returned to normal, and she has been symptom-free for 30 months.

Case 2. A seven-year-old female presented with a left-sided Wilms' tumor. There were pulmonary metastases at the time of diagnosis. Her initial treatment consisted of surgical resection of the primary lesion, chemotherapy, and radiation. Nine months later she presented with headaches, nausea, and vomiting. A radionuclide brain scan (Figs 2A, 2B) using ^{99m}Tc glucoheptonate (8.3 mCi/m^2) demonstrated metastatic lesions in the brain parenchyma. They were also shown by cranial CT scan. Biopsy confirmed metastatic Wilms' tumor. She received cranial irradiation. She was free of symptoms for six months at which time the lesions recurred.

Case 3. A ten-year-old male presented with a left-sided Wilms' tumor. Initial treatment consisted of surgery, chemotherapy, and radiation. Six months later he returned with headaches, nausea, and vomiting. In addition he developed bone pain. Bone and liver metastases were documented. A radionuclide brain scan using ^{99m}Tc-glucoheptonate (8.3 mCi/m^2) demonstrated an obliterated transverse sinus and a focal abnormality in this region (Figs 3A, 3B). A bone scan documented skull metastases (Fig 3C). A CT scan documented the skull metastases and epidural extension of tumor. Bone biopsy confirmed metastatic Wilms' tumor. He was treated with local radiation. CNS symptoms have not recurred in 12 months. He has not been restudied.

DISCUSSION. Wilms' tumor usually presents as an asymptomatic abdominal mass. In general metastatic disease is silent with the exception of the CNS. Effective therapy relies on accurate staging. This includes standard radiologic and radionuclide studies in addition to surgery and

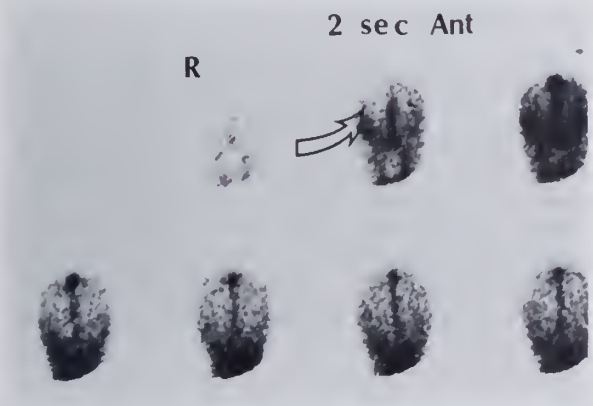

FIGURE 2A—Radionuclide angiogram. Arrow marks decreased perfusion of a cerebral metastatic lesion.

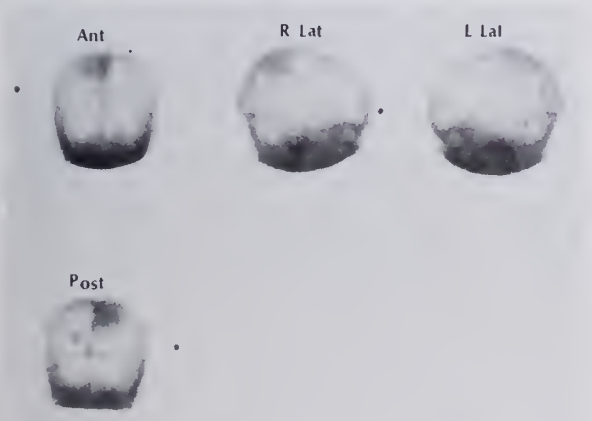

FIGURE 2B—Two-hour delayed brain image. Note the metastatic lesions (left occipital, left frontal, and right posterior parietal).

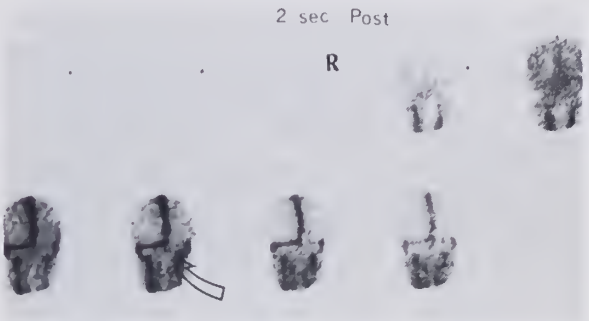

FIGURE 3A—Radionuclide angiogram. Arrow marks obliterated transverse sinus.

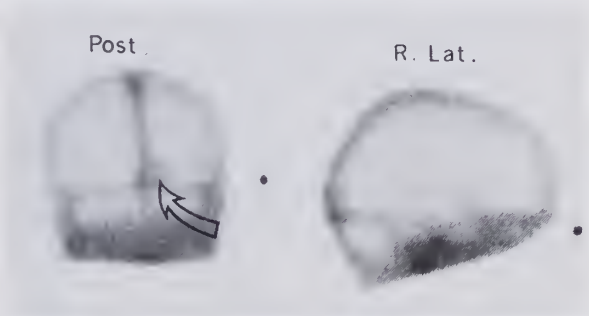

FIGURE 3B—Two-hour delayed brain image. Arrow marks focal abnormality.

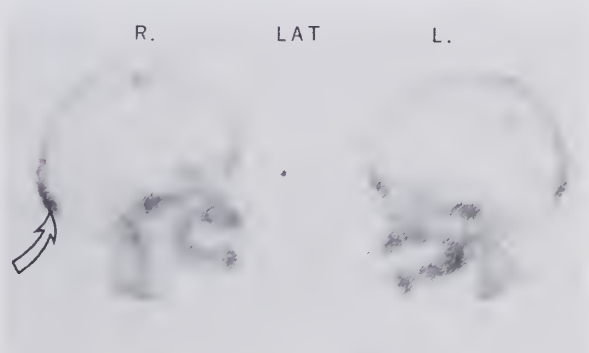

FIGURE 3C—Two-hour delayed bone image. Arrow marks skull metastases responsible for transverse sinus interruption (additional lesions are present).

pathologic examination.[13]

The initial evaluation of a child suspected of having Wilms' tumor is excretory urography. Arteriography usually is not necessary for diagnosis.[14,15] Abdominal ultrasound is useful in evaluating the mass for evidence of local invasion and thus complements the excretory urography. In addition, it is useful in assessing the regional lymph nodes in the renal hilus and in the perivascular channels above the renal veins.

Chest radiographs are essential for initial and followup evaluation since the lung is the most common site of metastases. Chest lesions usually are single or multiple pulmonary nodules. However, pleural metastases with effusions have been reported.

The liver is the second most common organ involved with metastatic tumor. Hepatic scintigraphy provides an accurate method of detection.

Bone metastases from Wilms' tumor are infrequent. In general the radionuclide skeletal survey provides more information than the radiographic skeletal survey in detecting metastatic bone disease in children.[16]

The brain is a rare site for metastases.[11] For this reason brain imaging is not routine. However, children with neurologic findings should be evaluated for CNS pathology. Wilms' tumor metastatic to the CNS may be epidural associated with skull metastases, leptomeningeal, or within the brain parenchyma as either solitary or multiple lesions. Brain scintigraphy is an accurate diagnostic modality for evaluating pediatric craniocerebral malignancy if carefully performed.[17]

In the three patients presented, CT scans documented the lesions that were demonstrated with radionuclide studies. In addition to detecting the lesions, CT scans distinguished the CNS involvement as either parenchymal, epidural, or leptomeningeal. It is possible, albeit more difficult, to make the same distinction with radionuclide imaging.

Because of the infrequent occurrence of CNS metastases with Wilms' tumor, routine evaluation of the CNS with radionuclide brain imaging is not recommended. However, if CNS symptoms develop, then radionuclide brain imaging provides a relatively inexpensive method to document CNS involvement.

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Abstracts

The breast reconstruction patient and her health insurance carrier

RICHARD V DOWDEN, MD; JOHN B McCRAW, MD; DAVID G DIBBELL, MD: University of Eastern Virginia, Norfolk, Va, and Univ of Wisconsin Center for Health Sciences, Madison, Wis: *JAMA* 242:2779-2782, 1979

To determine policies of health insurance companies regarding payment for breast reconstruction following mastectomy, we polled 50 companies selected at random, as well as every Blue Cross-Blue Shield company. To verify that insurance carriers' replies represented their practices, we polled 96 plastic and reconstructive surgeons in 47 states. Although most health insurance carriers claim to fully cover breast reconstruction following mastectomy for cancer, practices vary widely; many postmastectomy patients receive incomplete or no coverage for reconstruction. Two major reasons for discrepancies appear to be: (1) inadequate coverage prompted by unrealistic conception of reconstruction on the part of the carriers, and (2) specific contractual exclusion. We suggest: (1) educating lay and professional persons about breast reconstruction, (2) encouraging more realistic coverage from insurance companies, and (3) if necessary, legislative protection for the postmastectomy patient. ■

REFER TO—Amin OM, Nwokike FG: Prevalence of pinworm and whipworm infestations in institutionalized mental patients in Wisconsin, 1966-1976. *Wisconsin Med J* 79:31-32 (Mar) 1980

KEY WORDS—*Trichuris trichiura* and *Enterobius vermicularis* infestations, intestinal nematodes

Prevalence of pinworm and whipworm infestations in institutionalized mental patients in Wisconsin, 1966-1976

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The epidemiology, diagnosis, and treatment of whipworm, *Trichuris trichiura,* and pinworm, *Enterobius vermicularis,* among other intestinal nematodes, in the United States were recently discussed by Blumenthal (1977, *N Engl J Med* 297:1437-1439). This note reports the prevalence of these two nematode species in a representative sample of mental patients institutionalized at Wisconsin's Southern Colony (SC), Kenosha County between June 1966 and November 1976 by age, sex, and length of institutional residence. This is the first such report in Wisconsin or any of the North Central States.

Upon admission to SC, patients were screened for intestinal parasites and other infections. Periodic examinations were routinely made thereafter. The choice of subjects was limited to white patients coming from the same geographical region (southeast Wisconsin) that were admitted between June 1966 and November 1976 and with well-documented cottage and hospital records. Thus, records of 61 patients, age 6-54 years on admission (19 females, 42 males), constituting the study sample were screened for *E vermicularis* and *T trichiura* history (1966-1976) during 1976. The reported results are based on admission and subsequent SC hospital tests as well as on additional tests for *E vermicularis* for all previously selected 61 patients during 1976 by one of us (FN).

Diagnosis of *E vermicularis* and *T trichiura* infections was made by means of the Scotch tape swab (STS) and the Merthiolate-Iodine-Formalin (MIF) solution methods, respectively. Patients found infected with *E vermicularis* were examined one to three times per year with one to nine STS slides per examination. Those found infected with *T trichiura* were examined by the MIF method one to four times per year likewise with one to nine slides per examination. *E vermicularis* infections were promptly treated with piperazine or pyrvinium pamoate and those with *T trichiura* with thiabendazole in prescribed doses by body weight. Post-treatment tests were made at irregular intervals.

Twenty-nine of the 61 patients (47%) were infected with *E vermicularis* sometime between 1966 and 1976. This period prevalence is about half the prevalence rates reported from a pediatric institution (88% in 3-11 year olds) in Mississippi (Garrison et al, 1963, *Amer J Dis Child* 106:466-470), and an orphanage (88% in 4-16 year olds) in Vermont (Mathies, 1961, *Amer J Dis Child* 101:66-69) but similar to that from old men's asylum (45% in over 60 year olds) in Brazil (de Oliviara Gomes et al, 1965, *Hospital, Rio de J* 68:89-93). Males were more frequently infected (52%) than females (37%). This difference was not related to duration of institutional residence as infected male and female patients averaged eight years of residence at SC. Mathies (1961, loc cit) also reported a higher incidence of *E vermicularis* infections in male than female orphans above the age of 11 years. Prevalence of infection increased by age until 30 years, being 33, 61, 53 and 22 percent in 7-20, 21-30, 31-40 and 41-65 year olds, respectively (N=12, 23, 17, 9). The increase was more closely associated with the length of institutional residence being 27, 53, 55 percent in patients with 1-4, 5-8, 9-11 years of residence, respectively (N=15, 17, 29).

Two infection patterns were observed among the 29 patients infected with *E vermicularis.* The first involved 7 patients (24%) who had initial infections on admission. This initial incidence appears to vary with populations sampled during various years. Of 193 new admissions recorded

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between July 1970 and December 1971, 24 patients (12%) were infected on admission. By September 1973 the incidence of infection in that same population (July 1970-December 1971) increased to 19% (37 patients) despite treatment and some recoveries. This further supports the suggestion (above paragraph) that the length of institutional residence is related to increased prevalence of *E vermicularis* infestation. The other pattern involved 22 patients (76%) who showed evidence of institutionally acquired infestations and/or reinfestations. A similar prevalence of reinfestation (70%) was previously reported (Garrison et al, 1963, loc cit).

Seven patients (11%) were infested with *T trichiura;* four concurrently with *E vermicularis.* As with *E vermicularis,* prevalence of infestation was higher in males (14%) than females (5%) and increased by age, being 0, 9, 18 and 22 percent in 7-20, 21-30, 31-40, and 41-65 year olds. Higher incidence was also associated with length of institutional residence being 0, 6, and 21 percent in patients with 1-4, 5-8, and 9-11 years of residence, respectively. All seven infested patients showed evidence of persistent and/or institutionally acquired infections. ■

Abstracts

BRAIN STEM AUDITORY EVOKED RESPONSE

I. Basic principles and clinical applications in the assessment of patients with nonorganic hearing loss

KEVIN T KAVANAGH, MD and JAMES V BEARDSLEY, PhD; Gundersen Clinic, LaCrosse, Wis: *Ann Otol Rhinol Laryngol* 88:Suppl 58, pt 2 (July-Aug) 1979

A developing method for testing auditory function and detecting neurological disorders is the brain stem auditory evoked response (BAER) to sound stimuli. Elicitation of the BAER is noninvasive and produces an objective measurement of a subject's auditory function. Basic principles of this technique and normative data are presented in this paper. It was found that the BAER can detect asymptomatic high-frequency hearing losses. The sensitivity of this technique makes it an ideal method for evaluating functional hearing losses. Two illustrations of Functional hearing losses are presented. Wave V's threshold, latency and amplitude, along with comparisons between the auditory (subjective) and BAER threshold, are useful parameters when testing for nonorganic hearing disorders. However, this sensitivity to minor hearing losses makes it imperative that all control subjects be established as normal by an audiogram. A mere negative history for hearing disorders is felt by the authors to be an inadequate screening of control subjects.

II. Clinical application in the assessment of patients with organic hearing loss

KEVIN T KAVANAGH, MD and JAMES V BEARDSLEY, PhD; Gundersen Clinic, LaCrosse, Wis: *Ann Otol Rhinol Laryngol* 88:Suppl 58, pt 2 (July-Aug) 1979

This paper studies the effect of otologic disease on the brain stem auditory evoked response (BAER). Both conductive and neurosensory hearing losses are analyzed by plotting wave V latencies and amplitudes as a function of sound intensity. It was found that the BAER is elicited primarily by frequencies greater than 2000 Hz. Conductive hearing losses produce a latency intensity function which approaches the norm with high decibel stimulation. Neurosensory losses produce a variety of latency intensity functions. In determining the degree of hearing loss, wave threshold is found to be the best index. Wave latency at high decibels is found to have little correspondence to degree of neurosensory loss; wave amplitude is highly variable among subjects but still a useful indicator for detecting pathology. Between-ear comparisons of wave latencies elicited by high decibel sound stimulation suggest that unilateral nonrecruiting or partially recruiting hearing losses will result in a latency difference. This method can be used to detect unilateral acoustic neuromas, and the false positives found by this technique are probably caused by other unilateral nonrecruiting hearing losses. In evaluating neurological disease, and especially when testing for a second occult lesion in multiple sclerosis (MS) an audiogram should be obtained because the criterion of a normal wave latency with decreased amplitude for the diagnosis of MS can be mimicked by peripheral hearing loss.

III. Clinical uses of bond conduction in the evaluation of otologic disease

KEVIN T KAVANAGH, MD and JAMES V BEARDSLEY, PhD; Gundersen Clinic, LaCrosse, Wis: *Ann Otol Rhinol Laryngol* 88: Suppl 58, pt 2 (July-Aug) 1979

Brain stem auditory evoked responses (BAER) elicited by bone-conducted click stimuli were studied in 37 subjects. This technique was plagued

continued on page 34

REFER TO—Sty JR, Babbitt DP, Aronow CB: Diagnosis of an orbital abscess with ultrasonography. *Wisconsin Med J* 79:33-34 (Mar) 1980

KEY WORDS—Orbital abscess, ultrasonography, computer tomography

Diagnosis of an orbital abscess with ultrasonography

John R Sty, MD; Donald P Babbitt, MD and **Cedor B Aronow, MD**
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CASE REPORT. A 10-year-old boy had been well until three days prior to admission. At that time he developed painful swelling about the right eye. The periorbital area including the eyelids had a bluish discoloration. The lids were closed. The globe was difficult to evaluate. The radiographs of the paranasal sinuses demonstrated opacification of the maxillary and ethmoid sinuses. The white blood cell count demonstrated a left shift. The skin was aspirated and no organisms were recovered.

The child was treated with ampicillin and nafcillin without improvement. On the third hospital day an ultrasound examination was performed. This study demonstrated an abnormal fluid collection medial to the globe. The globe was displaced laterally (Fig 1). A computerized tomographic (CT) examination confirmed the ultrasound findings (Fig 2).

The child was operated on and a right subperiosteal abscess was drained. Rapid improvement followed.

DISCUSSION. The orbit is a pyramidal cavity composed of maxilla, zygoma, palatine, frontal, sphenoid, lacrimal, and ethmoid bones. Anteriorly the orbit is occupied by the globe of the eye, and posteriorly by loose areolar tissue, optic nerve and ocular muscles. From the periosteum of the orbit a connective tissue reflection forms a septum that terminates in the eyelids. This sep-

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FIGURE 1: Transverse ultrasound examination of right orbit. Arrow points to abnormal fluid collection. The location is between the ethmoid sinuses and globe.

FIGURE 2: Cranial computed tomography. Solid arrow points to the purulent material in the orbit. Note the opposite orbit for comparison.

tum forms the watershed between superficial and orbital soft tissue infection.[1,2]

Infection anterior to the septum is usually associated with trauma or skin infection. Sinusitis is not the major etiology. Preseptal cellulitis is analogous to cellulitis in other regions of the body.[2] Contrariwise, orbital cellulitis and abscess is a more serious infection. The risk of vision loss or metastatic intracranial spread requires immediate recognition and treatment. Surgical drainage and antibiotics constitute the therapy.

Frequently the entities can be distinguished clinically. In preseptal cellulitis the globe is not involved, while orbital cellulitis is characterized by proptosis, restricted mobility of the globe, and pain with movement of the globe. However, if there is marked edema, the clinical differential is less accurate. In this clinical situation ultrasonography or computed tomography is useful.

Ultrasonography has proved effective for evaluating orbital lesions, especially inflammatory disease.[3,4] In the case presented ultrasonography demonstrated the subperiosteal ethmoid abscess as well as displacement of the globe. This was useful in directing the surgical approach.

The computed tomography added no additional information. However, computed tomography may potentially provide more information than ultrasound. For example, CT will: (1) define sinus disease as well as bony structures, (2) evaluate bacterial seeding to the central nervous system, (and 3) allow comparison of both orbits so that minimal abnormalities can be noted.

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Abstracts

Chronic-persistent hepatitis and pregnancy

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Gastroenterology 77:524-527 (Sept) 1979

The course and possible risks of pregnancy were evaluated in seven women, aged 20 to 30 years, who had chronic-persistent hepatitis (CPH). Ten pregnancies occurred during the followup period. Four of the fetuses were aborted electively for nonmedical reasons. The other six pregnancies resulted in normal spontaneous vaginal deliveries at term. Each of the women experienced uneventful prenatal and postnatal courses, and the neonates were all healthy and normally developed at birth. There was no biochemical or clinical evidence to suggest worsening liver disease during pregnancy. Normal menstrual patterns when not pregnant and normal biphasic basal body temperature patterns in four women suggested that ovulation and fertility were not impaired significantly. Pregnancy in women with CPH seems safe for both mother and fetus alike.

Hepatitis B virus infection was the etiology of CPH in two patients who had developed hepatitis B surface antibody (Anti-HB_s) prior to their pregnancies. Vertical transmission of hepatitis B virus in the neonates did not occur. The possible risk of vertical transmission of hepatitis B virus, however, remains if the mother has evidence of hepatitis B antigenemia during pregnancy.

The relative safety of pregnancy in CPH contrasts with the fetal and maternal morbidity and mortality associated with cirrhosis and/or portal hypertension in pregnancy and which requires close collaboration amongst hepatologist, obstetrician and surgeon experienced in the management of cirrhosis and portal hypertension in a specialized obstetric unit. ■

BRAIN STEM continued from page 32

with problems such as: low amplitude, poor wave configuration, and calibration difficulties. The authors found the technique of limited value in differentiating conductive from neurosensory hearing disorders in all but severely affected subjects. It can, however, evaluate cochlear function in the presence of a known severe conductive hearing loss, *ie*, external ear atresia. If an abnormal bone-conducted BAER is obtained, the etiology of this abnormality (cochlear *vs* retrocochlear) cannot be ascertained because a wave I is rarely elicited in individuals with neurosensory hearing disorders. In subjects with a severe conductive hearing loss, air-conduction elicited markedly prolonged wave V latencies. Such a marked prolongation was not observed in individuals with peripheral neurosensory loss and when present signified that a subject had a major conductive component to his hearing disorder. The authors also believe that all control subjects should be established as normal with an audiogram and not by an otologic history or auditory (subjective) click thresholds. ■

Perinatology

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KEY WORDS: Adolescent pregnancy

Perspectives on adolescent pregnancy

David B Schwartz, MD, Madison, Wisconsin

EDITORIAL NOTE: The problem of adolescent pregnancy continues to present ever-increasing problems in need of effective solutions. The following article focuses on some of the most crucial problems and proposes a plan of management to deal with them and secure a successful outcome.

Pregnancy in the adolescent presents a number of potentially significant medical and nonmedical problems,[1,2,3] particularly for the group under the age of 16 years.[4] The problems are not only short-term medical and psychosocial in nature, but also there are usually long-term profound consequences for the patient, the child, her family, and society as a whole.[3] It is the purpose of this paper to deal with some of the more pertinent aspects of adolescent pregnancy.

The extent of the problem of adolescent pregnancy. National figures indicate that there are more than one million teenage pregnancies each year resulting from the 12 to 13 million sexually active teenagers in the United States. Approximately 600,000, or two-thirds, of these pregnancies result in live births which represent approximately one-fourth of the total live births occurring annually in the United States; and 30,000 of these pregnancies occur annually in girls under the age of 15 years. Furthermore, more than 90% of these pregnant teenagers keep their babies. It is likely that these figures will increase as two-thirds of these pregnancies were unplanned, and there is an anticipated continuing trend of increasing and unprotected teenage sexual activity.[5,6,7] The appropriate figures for the State of Wisconsin are noted in Table 1.

Medical and psychosocial consequences of adolescent pregnancy. Numerous studies have analyzed the many problems associated with teenage pregnancy.[3,4,5,6,7] The important obstetric problems include a prevalence of inadequate prenatal care secondary to the late diagnosis of pregnancy and the sporadic and infrequent attendance at clinics. There is a higher incidence of venereal disease and drug abuse. Inadequate nutritional intake and an associated anemia in pregnancy are very common. Prematurity and premature rupture of the membranes are reported more frequently. Preeclampsia is increased especially in those pregnancies occurring soon after the menarche. Cephalopelvic disproportion may also be increased in the very young adolescent in whom skeletal growth is not completed with resultant diminished pelvic capacity. These problems lead to an increased incidence of forceps delivery and Cesarean section. As a result of these complications, maternal and perinatal mortality and morbidity are increased. Table 2 indicates the incidence of some of these problems in a small group of 44 pregnant teenagers under the age of 16 years drawn from a larger sample of 150

Table 1: Wisconsin adolescent birth statistics

	1970	*1972*	*1975*	*1977*
Under 15 years	87	88	103	103
15 years	256	328	372	339
16 years	759	804	1102	886
TOTAL BIRTHS	77,455	64,719	65,145	68,548

Table 2: Adolescent pregnancy—1976 to 1979 (Maternal Intensive Care Program—Madison General Hospital)

First visit 25 weeks or less	65.0%
Unreliable dates	57.0%
Drug abuse	7.0%
Preeclampsia	13.5%
Cesarean section	22.0%

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patients attending the Single Parent Clinic of the Madison General Hospital Maternal Intensive Care Clinic between 1976 and 1979.

Followup studies of adolescent pregnancies have shown that without appropriate comprehensive care, the long-term outlook for patients and their children remains bleak.[4] Compared to controlled populations, the children's intellectual development and academic performance is impaired. The patients have more children at close intervals and with a higher perinatal mortality. The divorce rate is higher and marriages less stable with more frequent partner changes, especially in the first years following the delivery of their child when stability for the infant is so important. The patients themselves do not attain the satisfactory educational level necessary to enable them to pursue a vocation or achieve financially meaningful employment. Economic deprivation is therefore perpetuated and aggravates the cycle. This totally unsatisfactory situation has prompted the apt observation that adolescent pregnancy represents a syndrome of failure in so many of the aspects of healthy human development in our society. While all of these problems may not be applicable to any one particular case, and cannot be discussed in detail, it is important to be aware of this spectrum in planning appropriate care.

Management of adolescent pregnancy. It should be stressed that management involves not only medical care directed obstetrically but also the more comprehensive supervision of psychological, social, educational, and financial needs on an ongoing basis.[1,4,6] Optimum care would be provided by a team which includes physicians, nurses, social workers, counselors, nutritionists and teachers who would be involved both during and after the pregnancy. Programs utilizing this comprehensive approach in adolescent pregnancy have succeeded in eliminating, minimizing, or at least improving many of the previously listed problems.[4,8]

The physician must obviously play a leading role in the patient's care. While he or she may be most qualified to direct themselves at the obstetric aspects of the case, it often will be necessary to request assistance and guidance from other centers or resources in order to render the needed complete care that has been described.

The following aspects of prenatal care should be emphasized:

(1) A friendly, reassuring and supportive attitude is most important to establish the patient's confidence and trust.

(2) This will help ensure frequent prenatal attendance.

(3) The latter is essential for the early detection of obstetric problems such as preeclampsia and anemia, as well as to ensure appropriate nutritional supervision.

(4) Accurate pregnancy dating is important as so many patients have unreliable dates. Table 2 indicates that two-thirds of these patients were seen before the 25th week of pregnancy which permitted the use of ultrasound and the GASA system to more accurately date the pregnancies.[2] In this small sample 57% of the patients had unreliable dates and the meaningful use of ultrasound was possible in more than 60% of the patients.

(5) Counseling and support must be skillfully provided to the patient, her partner, and family, if possible. It should be remembered that the patient has to cope with all of the psychological adjustments of pregnancy, as well as the ongoing psychological adaptations and tasks of adolescence.

(6) The patient's schooling should be continued in the most appropriate setting, and education about the physiology of pregnancy, childbirth, and the puerperium must be dealt with.

(7) Ideally a designated support nurse should follow the patient consistently during the pregnancy and her labor.

(8) Contraceptive counseling should be started during pregnancy and her hospital stay.

The extended role of the physician. Ideally adolescent pregnancy should be prevented, and physicians in contact with this young, potentially fertile group should direct themselves to their contraceptive needs. When pregnancy is diagnosed in these patients, they should be fully counseled regarding the options of abortion where feasible or the possibility of continuing with the pregnancy; and whatever the decision, medical care and psychological support is required on an ongoing basis. Furthermore, it is the responsibility of caring physicians to act as innovators within their own environs to develop and establish the preventive and management services which are needed to deal with this truly significant problem.

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SPECIAL COMMUNICATION

Pregnancy out of wedlock —a growing problem

Ewald H Pawsat, MD, Fond du Lac, Wisconsin

Both the clergyman and the physician are in positions to be painfully aware of a growing problem—pregnancy out of wedlock—that now is rather commonplace in our society. It is difficult to deal with this subject in a brief presentation, although the following remarks have been put in capsule form.

I intentionally avoided the title, "Teenage Pregnancy," as the problem is, by no means, limited to the teenager. Later statistics will bear this out.

Also, the term illegitimacy has not been used. It has never seemed fair to a child, born under these circumstances, to be designated as illegitimate. Nor have I used the term illegitimate birth, as there appears to be nothing illegal about the condition by present-day legal standards. Recently mothers of children born out of wedlock have been given the "right" to give the child the father's or supposed father's, surname. Responsibilities of the fathers appear to be nil.

The statement, that children and youth today are no better and no worse than they were generations ago, has become a cliche. It was born of, and continues to be, the product of generalizations. Those of us who have been privileged to serve children and youth in some capacity over several generations find it difficult to accept such generalizations when documentations in some areas of their behavior point to very real deterioration.

Thus, my discussion is limited to pregnancy out of wedlock.

Since we have a common interest in the hospital setting, I have used statistics from our St Agnes Hospital in Fond du Lac. They are not big city or inner city statistics. They bring us face to face with what is happening in our own community. In my early years of practice a baby born to an unwed mother and cared for in our nursery was a rarity. Now we average one or two such babies in the nursery most of the time. The occasion, which in the past was handled very hush-hush, is now an open and accepted event.

Of special concern to me are events that have happened in the past six years. In 1973 our hospital recorded 49 births to unwed mothers. With an almost annual increase this number, in 1979, increased to 100 such births. It is only fair to state that during these six years, there has been a modest annual increase in births generally; from 1171 in 1973 to 1408 in 1979. Even considering this increase, the figures which in 1973 represented one baby born to an unwed mother for every 22 deliveries, in 1979 showed one such birth in every 14 deliveries.

In 1979 figures showed that 58 of the 100 babies born to unwed mothers had mothers who were 19 years of age or under. Thirty more were under 24 years. Two mothers were 14 years old. One mother was age 15. There were a number of repeat pregnancies in the overall group. Of course, these figures do not represent the total number of unwed mother pregnancies in our community. They do not include pregnancies terminated by abortion. They do not include premarital pregnancies in which couples were married prior to birth of the baby. They do not include unwed mothers of our community who delivered elsewhere.

Can we and should we ignore the implications of these statistics for our community? To what de-

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gree do these statistics represent present-day social, legal, moral, and spiritual misbehavior? How are these areas of misbehavior interrelated? Are they mutually compromising good behavior?

Understandably there always has been and probably always will be the frequently long courtship, with matrimony as a goal, falling prey to the ultimate intimacy between partners which can result in pregnancy. These pregnancies are almost always associated with mutual love and serious responsibility. There is a good chance of a subsequent successful marriage and little chance for abortion. In marked contrast, however, are the largely teenage pregnancies that result from casual sex, frequently between bare acquaintances. This is sex for entertainment. It represents irresponsible behavior. It has become a socially acceptable consequence of our so-called sexually active youngsters. It is not a product of love. There is little chance of marriage. There is a good potential for abortion. These latter pregnancies should be of very real concern to us.

Early in my practice pregnancies outside the family unit were not commonplace. Sexual promiscuity was controlled to a great degree by three fears, which today have all but left the behavior scene. These were the fear of pregnancy, the fear of venereal disease, and the fear of God in the sense that the individual, if he or she became involved, would not be living up to the image of Christ. Fear of pregnancy has been largely discounted through easily available prophylactic measures, not totally harmless and not totally effective. The supposed security of these measures, in my opinion, has only led to further promiscuity and an increased pregnancy rate when prophylaxis proves ineffective or is totally ignored in the participants haste to "go all the way." I believe this in spite of the claims to the contrary for some practices in the preventive field by Family Planning Clinics and social do-gooders.

Fear of venereal disease also has been largely discounted by a false sense of security in available methods of prevention and treatment. Here again, by fostering promiscuity, there has been an alarming increase in the incidence of these diseases as well as the breeding of a new venereal disease, difficult of detection and having ominous consequences if not treated (NGU bacterium; Chlamydia trachomatis). As expected this increase in venereal disease is most prevalent in our youth age group. A recent case in our practice demonstrated not one venereal disease but several—syphilis, gonorrhea, venereal warts, and trichomonas.

I am considerably less qualified than the clergy to dwell on the spiritual health and welfare of our present-day society. God is all-loving. God is forgiving. Does this give us, as God's children, society in general, the privilege of taking advantage of God's goodness through failure to emulate Christ by finding it convenient to discount, or totally ignore, God in serious misbehavior?

In a medical sense pregnancy out of wedlock is a disease (dis-ease). Diagnosis usually is not a problem. Prenatal care often requires special handling. Deliveries may be complicated. Later handling of mother and child frequently are complex. The real goal of therapy should be in prevention.

What is to be done? There are many factors that have contributed to the problem of pregnancy out of wedlock. Some of these can be stated in the form of questions. Should we propose to our youth and young adults a return to some of the fears that still are well founded for the control of promiscuity? Should we, as adults, set better examples for our children in our family living? Should we upgrade family love and unity with mutual respect between generations to better open lines of communication? Should parents refuse to abdicate supervision over their children and not be dethroned by forces which they cannot control? Should we discourage our children from looking to their peer groups for patterns of behavior and norms if these are not proper? Should we provide more help in combating ever greater peer group pressures towards misbehavior, especially in the use of alcohol and drugs and the increasing trend towards promiscuity? Have we been a bit remiss in allowing liberal teachings to invade our educational systems? Are evidences of our permissive society too readily demonstrated to our youngsters via the various media? Is there a greater need for supervision and restrictions? Is our government, with its legalization of some of our "thou shalt nots," serving to confuse our youth on what is right and what is wrong? Is our government often too quick to support, rather than condemn, the consequences of irresponsible behavior? Should we more often return to the precepts of the Ten Commandments spoken by God to Israel and delivered to Moses on Mount Sinai, for guidelines to norms of social, legal, moral, and spiritual behavior?

If our answer to each of these questions is a sincere "yes," we have gone a long way to convince ourselves, our children and youth, our young adults, and our fellowpersons, that pregnancy out of wedlock represents social, legal, moral, and spiritual misbehavior, which with the help of God and Christ-like teaching and example can, in incidence, show a great degree of reversal.

Although I have presented more questions than answers, I trust the questions will serve to provide further food for corrective thought and action on this subject; so that giving birth, the ultimate in human events may, more often, remain truly blessed. ■

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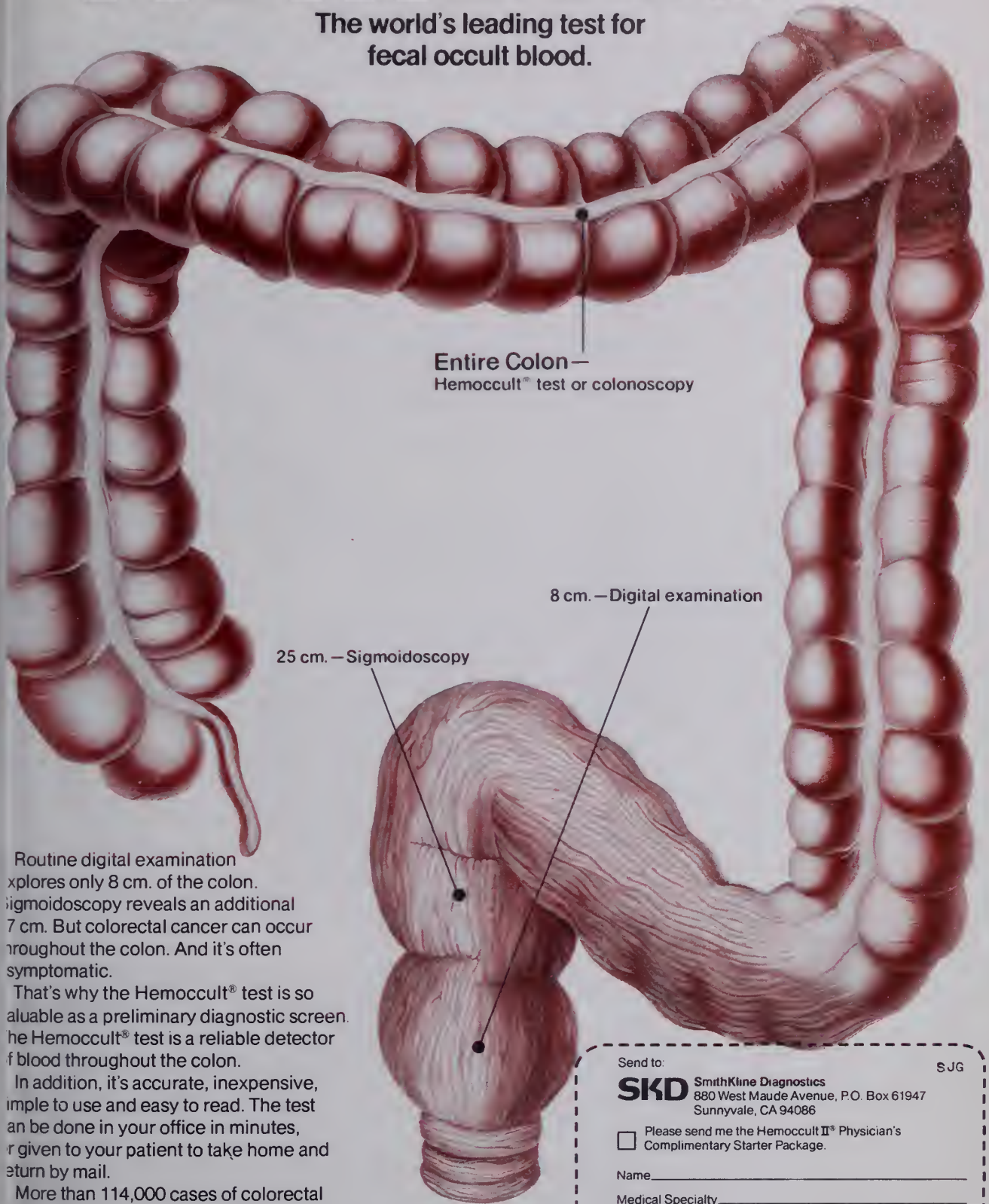

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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation, bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine* (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Tetrahydrocannabinol as an antiemetic for cancer patients

One of the major goals of good medical practice is to relieve suffering. Nausea and vomiting are two of the side effects of cancer treatment that many cancer patients dread the most. These side effects can be alleviated; however, the unpleasantness may cause a few to refuse treatment. Also, public awareness of these adverse effects of chemotherapy may influence the willingness of some patients to seek medical help and of physicians to refer patients for aggressive therapy. The nutritional impairment caused by nausea and vomiting may decrease the treatment's effectiveness.

Because the antiemetic drugs currently used are often only partially effective, interest in alternative drugs such as marijuana has been increasing. Recently there have been anecdotal accounts from patients who have smoked marijuana before receiving chemotherapeutic drugs and found their nausea and vomiting decreased, appetite increased, and anxiety reduced.

Although marijuana has been used by many people since the neolithic period, little was known about its pharmacology, chemistry, and pharmacokinetics until recently. Marijuana, or *Cannabis sativa* L., contains over 37 different cannabinoid compounds specific to *Cannabis* alone. The major active constituent is a compound called Δ^9-tetrahydrocannabinol (THC). Its content in fresh marijuana varies from 0.1% in Kansas hemp to 4% in Jamaican or Vietnamese specimens. Aging of the plant materials, resins, or extracts causes a significant loss of activity. The material is also very difficult to purify.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

THC was first synthesized in 1964. Systemic absorption is very rapid when inhaled, since the drug crosses the pulmonary capillary bed and enters the systemic arterial supply without passing through the liver. THC is lipid soluble, so it enters tissues rapidly and plasma levels become very low soon after administration. THC is also rapidly metabolized, especially after oral administration, due to hepatic hydroxylation. One hydroxylated metabolite is active and may account for the activity of orally administered drug, but the other hydroxylated metabolites are inactive. A significant enterohepatic circulation of drug and metabolites exists. Lipid-soluble conjugates are excreted in the bile.

In humans THC has well-defined, dose-related somatic effects such as objective impairment of coordination, conjunctival injection, pseudoptosis, loss of muscle strength, tachycardia (especially supraventricular), and slow spontaneous movements.

Behavioral effects include euphoria and a subjective impression of heightened perception of visual, auditory, and tactile sensations, but indifference to the environment. Uncontrollable laughter and increased appetite are commonly observed, but aggressive behavior is decreased with patients becoming mildly somnolent. Hallucinations are generally pleasant, but there may be a sensation of depersonalization and unreality, associated with distortions of time sense and some loss of memory. These hallucinations often shade into sensations of panic, fear, and actual paranoia that are frequently more severe in older, drug-naive patients. These dysphoric reactions are the most serious side effects. Fortunately patients usually respond to reassurance, and the ill effects are often transient and may not recur on subsequent treatment.

To understand treatment of nausea and vomiting, the physiology of the process must be under-

stood. Emesis and retching are controlled by the emesis center located in the lateral medullary reticular formation, anatomically adjacent to loci concerned with salivation, spasmodic respiratory movements, forced inspiration, and vasomotor reactions which are the efferent arm of the emesis reflex. The emesis center is influenced by labyrinthine afferents, visceral afferents, vagal afferents, the chemoreceptor trigger zone, and stimuli from the cortex triggered by the psyche, sight, taste, odor, or conditioning. Depending upon the activating pathway, the effects of antiemetics vary. For example, the chemoreceptor trigger zone in the floor of the fourth ventricle is stimulated by apomorphine; this effect is blocked by phenothiazines. By contrast, antihistamines block labyrinthine-mediated emesis but not chemoreceptor trigger zone responses.

Since the cortex may be stimulated by various stimuli, the setting (whether outpatient or inpatient), the intent of treatment (whether adjuvant, curative, or palliative), the attitude of the medical staff, dose, schedule, prior experience, patient attitudes, and other concurrent drugs may all influence the effectiveness of the antiemetic treatment.

Experimental studies have shown that oral THC is superior to placebos and that the antiemetic effect is associated with a subjective "high" and elevated THC serum levels. THC appears to be at least as effective as prochlorperazine (Compazine®) but may have more significant central nervous system (CNS) side effects. THC is effective in some patients who are refractory to other antiemetics and is also more effective against the effects of high-dose methotrexate, BCNU, or radiotherapy than against emesis induced by cyclophosphamide (Cytoxan®) or doxorubicin hydrochloride (Adriamycin™) plus Cytoxan®. Tolerance after repeated treatments has been observed. Patients at risk for toxicity probably include those with a drug-abuse history, psychiatric disorders, cardiac disease, or an "additive" personality. These patients should be closely monitored.

Today THC is a controlled substance which physicians cannot prescribe without a special arrangement with federal regulatory agencies. A stable, parenteral form of THC is needed. The development of an effective, less toxic analog would help both legal and medical aspects. One possibility is Nabilone® which has been shown to be superior to Compazine®. Unfortunately it has been withdrawn from clinical trials because of the accumulation of carbinol metabolites following chronic administration to dogs. A variety of other antiemetics, such as butyrophenones and metoclopramide, has been reported to have activity. Presently there are several studies underway which may help us make a rational choice of antiemetic therapy.

—Robert H. Earhart, MD, PhD
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Organizational SMS

Legislative committee rejects malpractice fund rule

The Legislature's Joint Committee for the Review of Administrative Rules (JCRAR) has blocked the promulgation of an administrative rule developed by the Commissioner of Insurance designed to establish new accounting procedures for the Patients' Compensation Fund. The Committee action in early February prevents the Commissioner from immediately establishing a procedure which would have permitted total "reserving" for claims to the Fund which have occurred but have not as yet been reported. These claims, commonly called "IBNRs" (incurred but not reported), if reserved according to the Commissioner's rule would have reserved $15.5 million for unreported claims but cause a "paper deficit" of $4.4 million by 1982. This "deficit" would trigger a cap on awards and a special fees assessment against all physicians, hospitals, and others who pay into the Fund.

Earlier this year the Assembly Financial Institutions Committee voted 12-1 to recommend rejection of the rule. Under a new rules procedure enacted by the Legislature in mid-1979, all state agencies must now seek legislative approval of rules and regulations developed in response to state-administered programs.

The Committee agreed to reject the rule pending the development of a new "compromise" rule as well as legislation to be worked out between the Commissioner and the SMS Physicians Alliance. This compromise involves the following points:

(1) Development of a rule which, while permitting reserving for IBNRs, would require that the reserves be "discounted" according to the anticipated pay-out of the claim in the future. This "discounting" system will save anywhere from $2-3.5 million per year and will maintain a constant "paper balance" in the Fund.

(2) The Alliance agreed to support legislation to remove the current 10% ceiling on assessments to physicians (physicians currently pay 10% of their insurance premiums into the Fund to pay awards). While the cap on assessments will be removed, the Commissioner will be required to set assessment levels every year via an administrative rule—a process which involves legislative review and approval; and hence, the ability of the Alliance to affect the assessment level is greatly enhanced. SMS actuaries agree that this cap must be increased in order to preserve Fund solvency.

(3) Actuaries representing the State Medical Society will be formally involved in the development and application of the accounting principles used to determine Fund assessments. Currently, SMS is not involved directly in these decisions.

(4) The Insurance Commissioner's authority to impose a limitation on awards is removed. In other states such limitations have been declared unconstitutional and could have jeopardized the Fund's future.

(5) The Commissioner's authority to levy a special fee assessment is removed.

Senate Bill 565 which represents the compromise reached by the Alliance and Commissioner was to receive Senate floor action on February 28. ■

Legislature in session: psychology bill killed

A bill mandating all health insurers in Wisconsin to pay for psychologists' services performed without referral by a physician was defeated by the State Senate in January. Presently, patients must be referred to a psychologist by a physician. The State Medical Society strongly opposed the bill (AB 67) and charged that the measure would drive up health insurance costs and destroy the concept of cost-efficient group plans. Furthermore, the Society disputed the contention by proponents of the bill that psychiatrists and psychologists provide equal services to patients. Psychiatrists, the Society pointed out, provide a full range of psychiatric treatment, not just psychotherapy, and may render medical treatment and diagnosis.

Other bills receiving legislative action in recent weeks include:

- AB 913, a bill which eases the standards for involuntary commitment in Wisconsin, was passed by the State Assembly on an 88-8 vote. The bill now goes to the Senate Judiciary and Consumer Affairs Committee. SMS supports upon recommendation of its Mental Health Committee.
- SB 181 which would legally recognize brain death as the "irreversible cessation of all functions of the brain" was *defeated* by voice vote in the Senate. SMS supported the bill.
- AB 326 which creates a "discovery rule" for malpractice actions has passed the Senate and at press time awaits the Governor's approval. The bill allows individuals to commence medical malpractice actions within three years from the date of the injury or from one year from the date of discovery, not to exceed five

years. Present law only allows actions to be brought within three years from the date of the injury.

• The Assembly has passed AB 246 authorizing ambulance attendants under the direction of a physician to receive and provide treatment (including injections) to victims of anaphylactic shock. The bill now goes to the Senate for approval. SMS supports the bill.

• AB 209 which would expand the membership and broaden the powers of the Radiation Protection Council has passed the Senate. It now goes to the Assembly. SMS supports the bill.

• The Governor's veto of AB 243, which would prohibit anyone from charging a fee for completing a "disability claim form," was upheld by the State Assembly February 6. SMS opposed the bill. ■

Nurse-midwife bill passes Assembly, Governmental Affairs to seek amendments

The State Medical Society of Wisconsin will seek further amendments to a bill establishing a nurse-midwife program in Wisconsin, the SMS Governmental Affairs Commission decided at its February meeting. A substitute version of the bill, AB 66, was approved by the State Assembly February 5 which the Commission felt did not adequately address all of its concerns.

The bill passed by the Assembly requires that the practice of nurse-midwifery be "spelled out" under a contractural agreement between a nurse-midwife and an *obstetrician;* that the midwife must practice under the supervision of a physician; and that the care rendered by the midwife be performed in a "facility" as determined by the State Board of Nursing. The Commission now is seeking changes in the bill to allow the nurse-midwife to work under a contractural agreement with a *physician,* and that midwife care be rendered in a "medical facility."

In other action February 13, the Commission went on record as supporting a bill which would grant immunity to physicians and hospitals for discontinuing or withholding medical treatment from a person with irreversible cessation of brain functioning. ■

Recommendations sought for AMA councils and committees

The AMA Council on Medical Education is in the process of soliciting recommendations for AMA appointments to several councils and committees. These include: Council on Medical Education, Advisory Committees of the Council on Medical Education, Residency Review Committees, Coordinating Council on Medical Education, and others. The AMA is requesting that state medical societies submit by May 9 recommendations for these positions.

SMS physicians who are interested in making a recommendation should contact SMS Secretary Earl Thayer, PO Box 1109, Madison, Wis 53701 (phone 257-6781 or toll-free 800/362-9080) for a complete list of councils and committees for which recommendations are requested, as well as a list of criteria and procedures to be used by the Council on Medical Education in reviewing the recommendations for action by the AMA Board of Trustees.

The Council on Medical Education is one of eight AMA councils. It is headed by Robert T Kelly, MD of Grand Rapids, Minn, chairman, and John Glasson, MD of Durham, NC, vice-chairman. ■

CONTRIBUTIONS CES FOUNDATION JANUARY 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for January 1980.

Nonrestricted

Manitowoc County Medical Auxiliary; Eau Claire-Dunn-Pepin County Medical Auxiliary; SMS Members—*Voluntary Contributions*

Restricted

Membership Dues—*Aesculapian Society*

Memorials

Dr-Mrs Robert T Schmidt; Brown County Medical Auxiliary—*Helen Urban (Brown County Loan Fund)*

Mrs Cyrus Reznichek & Family—*Mrs Dora Franklin (CG Reznichek, MD, Student Loan Fund)*

Marathon County Medical Auxiliary—*Marathon County Medical Auxiliary Loan Fund*

Mr-Mrs Joseph Neufeld; Dr-Mrs JM Guthrie; Mrs CO Small; Mr-Mrs Walter Hobbins; Mr-Mrs Peter Dorsckl; Mr-Mrs Sanger Powers; Mrs Margaret Carroll Clark; Mr-Mrs Olaf Larson; Mr-Mrs JH Feldmann, Jr; Dr-Mrs John Zellner; Dr-Mrs Steward L Griggs; Mr-Mrs Howard Levitas—*Vera Sterling (Brown County Loan Fund)*

Herman J Dick, MD—*Agnes Gannon Dick*

Dr-Mrs George F Meisinger—*Miss Yockey*

State Medical Society—*Evan B Davies, MD; Howard F Schloemer, MD; George J Kelm, MD; Otto A Mortensen, MD; Ann A Cinelis, MD; James W Mac Gregory, MD; Jacob H Lundstrom, MD; William B Rydell, MD; Lillian M Thomas, MD; Franz R Muehlhaus, MD; Frederick S Selle, MD; Budd A Gorsky, MD; Morris Kretchmar, MD; Arthur H Olsen, MD*

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of January 31, 1980

NEW MEMBERS

County Medical Society

BROWN

Bottsford Jr, John E, 1551 Dousman St, Green Bay 54303 (1935, Regular, General Surgery/Cardiovascular Surgery, Certified-GS)
Brault, Robert G, 704 South Webster Ave, Green Bay 54301 (1932, Regular, General Surgery/Thoracic Surgery, Certified-GS)
Nordell, Charles, 3415 Hilltop Way, Green Bay 54301 (1945, Regular, Internal Medicine/Gastroenterology, Certified-IM)
Walbrun, Fred H St Augustine St, Pulaski 54162 (1950, Regular, Internal Medicine)

DANE

Anderson, Alton D, 5110 Manitowoc Parkway, Madison 53705 (1918, Regular, General Surgery, Certified)
Anderson Jr, Ashley G, 2509 Norwood Pl, Madison 53705 (1951, Resident, Otorhinolaryngology)
Britton, Daniel E, 30 South Henry St, Madison 53703 (1941, Regular, Neurology, Certified-PN)
Bryan, Albert R, One South Park St, Madison 53715 (1934, Regular, Pulmonary Diseases/Internal Medicine)
Dyreby Jr, James R, 3124 View Rd, Madison 53711 (1953, Resident, Orthopedic Surgery)
Hill, John A, 20 South Park St, Madison 53715 (1943, Regular, Anesthesiology)
Jantz, G Keith, 7100 Mineral Point Rd, Madison 53717 (1949, Regular, Internal Medicine, Certified)
Kozarek, John A, 7127 Elderberry Rd, Middleton 53562 (1950, Regular, Radiology/Neurology, Certified-R)
Kwon, Tea Gil, 3473 B Memorial Drive, Madison 53704 (1939, Regular, Child Psychiatry)
Wise, James P, 20 South Park St, Suite 401, Madison 53715 (1943, Regular, Ophthalmology, Certified-OPH)

DOOR-KEWAUNEE

Stevenson, John E, 854 South 14th Ave, Sturgeon Bay 54235 (1940, Regular, Pulmonary Diseases/Internal Medicine, Certified-IM)

MILWAUKEE

Bauer, William 2130 North Mayfair Rd, Milwaukee 53226 (1926, Regular, Psychiatry)
Good, Jeffrey M, 1009 North Jackson St, Milwaukee 53202 (1947, Resident, Obstetrics and Gynecology)
Guansing, Alejandro R, 17535 Oak Court, Brookfield 53005 (1937, Regular, Internal Medicine/Endocrinology, Certified-IM)
Ivanovic, Zoran, 5458 South Tuckaway Lane, Greenfield 53221 (1935, Resident, General Surgery)
Kasner, Joseph R, 620 N 19th St, Milwaukee 53233 (1942, Regular, Nuclear Medicine, Certified)
Koh, Charles H, 2320 North Lake Dr, Milwaukee 53211 (1942, Regular, Obstetrics and Gynecology)
Slota, Catherine M, 6748 Hill Park Court, Greendale 53129 (1951, Regular, Pediatrics)
Sullivan, Dennis M, 1218 West Kilbourn Ave, Milwaukee 53233 (1947, Regular, Orthopedic Surgery)
Tenge, Jack R, 6001 West Center St, Milwaukee 53210 (1947, Regular, Pathology/Clinical Pathology, Certified-PTH)

POLK

Ebling, Paul F, 126 Burman Ave, Amery 54401 (1950, Regular, Family Physician)
Hanson, Allen S, 208 South Adams St, St Croix Falls 54009 (1950, Family Physician, Certified)

WOOD

Conway-Niehaus, Rebecca, 524 North Apple St, Marshfield 54449 (1948, Resident, Internal Medicine)

COUNTY-TO-COUNTY TRANSFER

Dane to Door-Kewaunee: Dean, James L, 345 South 18th Ave, Sturgeon Bay 54235
Dane to Milwaukee: Garsha, Larry S, 12501 Lakeshore Dr, Mequon 53092
Dane to Milwaukee: Hanson, Jerome T, 161 West Wisconsin Ave, Milwaukee 53203
Dane to Sheboygan: Larson, Christopher, 1204 North 4th St, Sheboygan 53081
Fond du Lac to Dane: Hutter, Adolph M, 34 Golf Course Rd, PO Box 8340, Madison 53708
Grant to Milwaukee: Nuland, Stanley J, 6430 North Sunset Lane, Milwaukee 53217
Vernon to Juneau: Balder Jr, Roy B, 1104 Academy St, Elroy 53929

DEATHS

Andrew, Carlton H, Grant County, Jan 20, 1980 ■

Obituaries

◊County, State, AMA Members

◊ **Jacob H Lundstrom, MD,** 82, Elkhorn, died Dec. 5, 1979 in Elkhorn. Born Dec 5, 1897 in Little River, Kan, Doctor Lundstrom graduated from Northwestern University School of Medicine in 1926. He practiced medicine in Highland Park, Ill, from 1928 until retiring to Elkhorn in 1968. Surviving are his widow, Bernice, and a daughter, Mrs Greta Menke of Bristol.

◊ **Carl H Andrew, MD,** 88, Platteville physician, died Jan 20, 1980 in Lancaster. Born Dec 12, 1891 in Livingston, Doctor Andrew graduated from Marquette University School of Medicine. He served his internship at Johns Hopkins Medical School. Doctor Andrew served in the United States Army Medical Corps during World War I. Surviving are his son, Col George Andrew of San Antonio, Tex, and a daughter, Mrs L L (Margaret) Jurgemeyer of Clinton, Iowa.

Lyle G Phillips, MD, 85, formerly of Fond du Lac, died Jan 29, 1980 in Honolulu, Hawaii. He graduated from Rush Medical College in Chicago and served an internship at Queen's Hospital in Honolulu. He practiced obstetrics and gynecology in Honolulu until his retirement in 1962. Surviving are his widow, Christine, and son of Honolulu. ■

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ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Eugene E Eckstam, MD* and **William L Maddix, MD,*** members of the medical staff of The Monroe Clinic, recently were appointed to committees of the American Group Practice Association. Luther M Kelly, MD, president of the board of trustees of AGPA, announced that Doctor Maddix was appointed as a member of the bylaws committee and Doctor Eckstam was appointed as a member of the credentials committee for 1980.

Roger S Gray, MD,* Evansville physician for 30 years, recently received the Evansville Jaycees Distinguished Service Award for 1980. Doctor Gray graduated from Marquette University School of Medicine and served his residency in Madison. As a member of the Health Planning Council, medical director for the Continental Manor, Evansville, member of the medical staff of Stoughton Community Hopsital, and team physician for the high school athletes, Doctor Gray has been active in many community affairs.

Roger W Baxter Jr, MD, Marshfield, has joined the medical staff of Marshfield Clinic. He graduated from Baylor College of Medicine, Houston, Tex, and completed his internship with the US Army at Letterman Medical Center, San Francisco. Doctor Baxter served with the US Army Health Sciences Center at Fort Sam Houston near San Antonio, Tex and did a year's emergency medicine work at Harris Hospital, Fort Worth, Tex. He completed a residency in radiology at the University of Texas Medical School and affiliated hospitals.

Charles* and Kim Awen, MDs, Oconto, are shown above aboard the ss STATENDAM ship during a Caribbean medical seminar at sea sponsored by Baylor University Medical Center, Dallas, Texas. The husband and wife team sailed out of the Port of Miami, Florida earlier this year.

George T Anast, MD, orthopedic surgeon at Howard Young Medical Center, Woodruff, recently returned from Munich, Germany, where he spoke at a seminar sponsored by the Department of Orthopedics at the Technical University in Munich. The subject of Doctor Anast's talk was "tears of the rotator cuff of the shoulder," a subject he has been interested in for many years.

Elke Werner, MD, Algoma, recently became associated with the Algoma Clinic. Doctor Werner graduated from the University of Wisconsin Medical School, Madison, and did her residency training at Midland Hospital in Midland, Mich. She took a three-month course at the Liverpool School of Tropical Medicine and also trained at the Institute of Child Health in London. Prior to joining the Clinic, she had been practicing medicine in a mission hospital in Malawi, Africa.

Jack D Brown, MD,* Sparta, has been appointed a member of the Mayo Medical School faculty. Doctor Brown's appointment is in recognition of his interest in participation in education and/or research activities of the institution and the excellent performance in carrying out those responsibilities. He has been a preceptor in the Department and Division of Family Medicine for the past four years.

George C Schulte, MD,* Kenosha, recently commemorated 45 years of outstanding service and dedication to medicine. Abbott Laboratories presented him with an engraved Golden Hour Clock commemorating this occasion. Doctor Schulte is shown above, right, with Abbott sales representative Kenneth Stewart.

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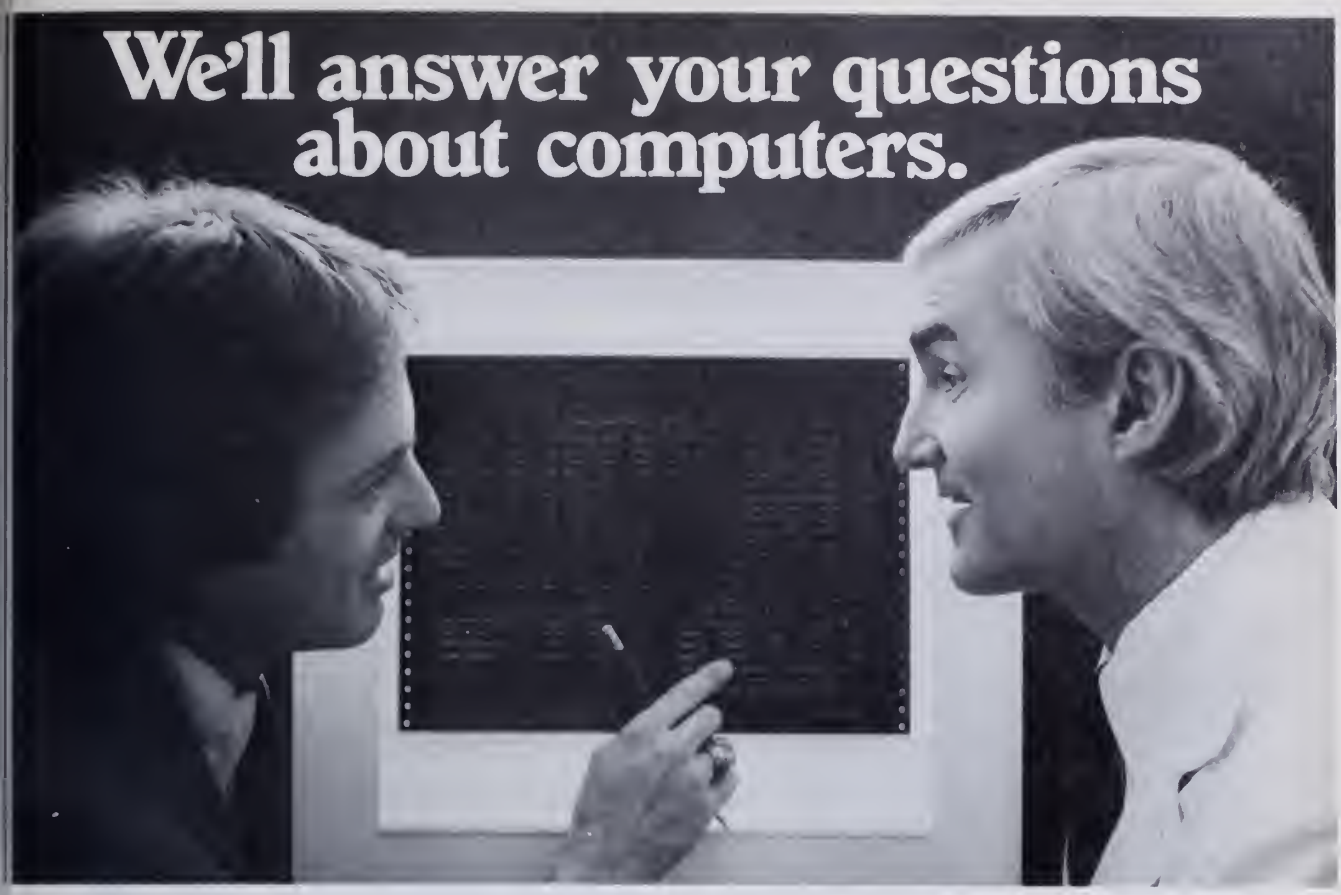

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Farrell F Golden, MD,* Madison, recently was honored by the city of Watertown for his services as a radiologist to the community for the past 30 years. For many years Doctor Golden has been driving to Watertown two days a week and Portage two days a week as well as having worked for 20 years at the Dean Clinic in Madison. He will continue to go to Portage and will substitute for Madison radiologists. In addition, he plans to do work in radiological anatomy at the University of Wisconsin.

From left: Pierce J Meier, MD, Watertown, hospital radiologist who will take over Doctor Golden's work; Mrs Golden holding a picture of her husband drawn by a Watertown artist; Doctor Golden holding the plaque he received from the Watertown Memorial Hospital Association; and James Becker, supervisor of the radiology department at the hospital and master of ceremonies for the event (see article above).—Photo courtesy of *Watertown Daily Times*

Austin J McSweeny, MD, Janesville, has contributed a chapter to the book "Applications of Hypnosis in Sex Therapy." This was published recently by Charles C Thomas of Springfield, Illinois.

Lee Huberty, MD,* Kenosha, recently was elected president of the medical staff of St. Catherine's Hospital in Kenosha. Other MDs elected to office are Hugh P Rafferty,* Kenosha, president-elect; John A Sanson,* Kenosha, secretary; Walid Burhani,* and Kulwant S Dhaliwal,* Kenosha, and Goro Tsuchiya,* Racine, to the executive board. Roman V Bilak, MD,* Kenosha, was appointed chairman of the surgery committee and Raymond Knight,* Kenosha, was appointed chairman of the medicine-family practice committee.

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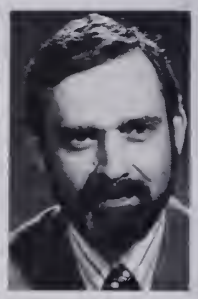
Eugene H Betlach, MD,* at the annual meeting of Mercy Hospital, Janesville, was elected chief-of-staff. Elected to serve with him are MDs Rocco J Vitacca, president; Paul Frechette,* president-elect; and Thomas G McCall,* secretary-treasurer of the medical staff. All of the physicians are from Janesville.

Lawrence Burkert, MD,* Brookfield, recently was elected chief-of-staff of Elmbrook Memorial Hospital, Brookfield. He will take office in December 1980 and is presently secretary-treasurer of the medical staff. Donald Luedke, MD,* Brookfield, was elected chief of the Department of Medicine and has been on the medical staff since 1969. John Blackwood, MD,* Brookfield, was elected chief of the Department of Surgery. Doctor Blackwood has been on the medical staff since 1971.

Doctor Pisciotta



Doctor Cox

Doctor Bonchek

Lawrence I Bonchek, MD,* River Hills, recently accepted a two-year term as president of the professional staff of the Milwaukee County Medical Complex. Doctor Bonchek, Director of Cardiothoracic Surgery, succeeds James E Youker, MD,* Milwaukee. Anthony Pisciotta, MD,* Elm Grove, Director of Hematology, was elected vice-president, and James D Cox, MD,* Shorewood, Director of Radiation Therapy, was elected secretary. All are full professors on the faculty of the Medical College of Wisconsin and they represent the 890 attending and consulting physicians staffing the Medical Complex.

Wisconsin running weekend

Running enthusiasts from around Wisconsin and the United States will have an opportunity to spend an evening with running authority George Sheehan, MD, and compete the following day in the Seventh Annual Madison Marathon at a special Wisconsin Running Weekend being sponsored April 11-12 by the State Medical Society of Wisconsin and the Madison Marathon Association. Further details appear on the opposite page. ■

WISCONSIN RUNNING WEEKEND

Madison – April 11 & 12

An Evening With DR. GEORGE SHEEHAN

sponsored by the State Medical Society of Wisconsin
8pm, Friday, April 11 – MATC Auditorium, $3.OO/person
pick up tickets at MATC registration Friday

MADISON MARATHON

sponsored by the Madison Marathon Association
8am, Saturday, April 12
Starts at the Capitol Square and ends at Olin Park

Course - 2 laps around Lake Monona (approx. the Monona 20K course) ★ Splits every mile ★ 12 aid stations ★ Six divisions ★ T-shirts to all finishers ★ Accurate & complete results to all ★ Entry fee - $5.00 until Tuesday, April 8; $6.00 after April 8; $10.00 on the day of the race ★ Expect course certification by race day ★ Pick up numbers and late registration — Friday at MATC Auditorium, 6-9pm; Saturday at the Inn on the Park, 6:30-8am ★

Make check out to **Madison Marathon** and mail entry to State Medical Society of Wisconsin; Madison Marathon;P.O. Box 1109; Madison, WI 53701 Phone (608) 257-5781

☐ Marathon Entry _____tickets for Dr. Sheehan

Name _____ Age _____
Address _____ M F
City _____ State _____ Zip _____
Club or Affiliation _____
Division - Check one only!
☐ 18 & under; ☐ open; ☐ 30-39; ☐ 40-49; ☐ 50+; ☐ Women

Waiver — to be signed by athlete

I hereby absolve the Madison Marathon Association, the Vilas Running Club and all race officials from any liability incurred by me from my participation in the Madison Marathon.

Signed: _____ date: _____

Parent/Guardian if under 18: _____

Robert G Wochos, MD,* Green Bay, has been named to the University of Wisconsin Medical Alumni Association board of directors. The board appointed him to replace Thomas R Leicht, MD, a director since 1978 who resigned because of his moving to Los Angeles. Doctor Wochos has practiced general surgery since 1953 in Green Bay, where he is associated with the Beaumont Clinic. He is a member of the Wisconsin Surgical Society and in 1976 was president of the Wisconsin Chapter of the American College of Surgeons.

George W Wirtanen, MD,* UW-Madison professor of radiology and human oncology, recently was named associate director of the Wisconsin Clinical Cancer Center and head of the Division of Radiation Oncology at the UW Medical School. Doctor Wirtanen's work focuses on a unique type of radio-therapeutic tumor localization and the use of intra-arterial chemotherapy and radiotherapy for the treatment of unresectable tumors.

Henry A Peters, MD,* Madison, in December joined his four sons in the Civic Chorus and the Madison Symphony Orchestra's production of "Elijah" in the University Pavilion. Doctor Peters is a long-standing member of the Chorus, having joined in 1951. However, the December production was the first time all of his sons, Henry Jr, Kurt, Eric, and Mark, joined him. The two elder sons, Henry and Kurt, have been with Civic Chorus for six years while the younger ones are new members.

John M Irvin, MD,* Monroe, recently was named president of the medical staff of St Clare Hospital, Monroe. He has been in medical practice in Monroe since 1951 and is a founding partner of The Medical Center of Monroe.

Thomas C Meyer, MD,* chairman of the University of Wisconsin-Extension Department of Continuing Medical Education, recently received the Distinguished Service Award from the University Extension. Doctor Meyer was appointed to his Extension post in 1965 when he started developing a program which now meets continuing education needs of physicians throughout Wisconsin. He pioneered in using telephone conferences as a medium for continuing medical education, with a total of 286 physicians taking part. These early efforts have evolved into the UWEX Educational Telephone Network (ETN) which last year was used by over 30 UWEX departments to reach more than 30,000 participants. Doctor Meyer established the first telephone Dial Access system for health information in the United States and also developed the program called Individual Physician Profile.

Doctor Meyer

Frank Weston, MD,* Madison, was featured in the Winter 1980 issue of the *Wisconsin Medical Alumni Quarterly*. An avid walker, the 81-year-old doctor uses a "Weston Walker," a sturdy walking stick he made from a sapling cut from the northern woods. Doctor Weston has been making Weston Walkers for about seven years. He says "the best part of using the stick while walking is that you don't have to lean over. Because of its height, you can hold your hand very high. That keeps you upright, and it gives you better balance, too." Doctor Weston began his walking when after a back operation in 1970 he had to learn to walk over again. He's not sure how many sticks he has made and given away, but his children think in terms of 1000 or more. He and his wife both use them as they travel around the country, producing a wide circle of new friends who have taken up the walking habit with the aid of the Weston Walker. Doctor Weston spent 43 years on the University of Wisconsin-Madison Medical School faculty, and the new Clinical Sciences Center library bears his name. He also was for many years treasurer of the State Medical Society of Wisconsin.

Doctor Weston with his Weston Walker. —*Wisconsin State Journal* photo

Mike Woods, MD, Milwaukee, a resident in anesthesiology at the Medical College of Wisconsin, was a participant in the Winter Olympics at Lake Placid, New York. A graduate of MCW in May 1979, Doctor Woods began his residency in the anesthesiology research laboratory at the VA Center, Wood, for two months. The interim months of his residency spent in Olympic training have been deferred. Doctor Woods acknowledges with appreciation the cooperation of MCW and the chairmen of anesthesiology who have encouraged him to pursue skating. He entered speed-skating competition at the age of 12 as a member of a West Allis club.

Bonnie Hough, MD, Whitewater, recently joined the medical staff of Stephen Ambrose Health Center, University of Wisconsin-Whitewater. Doctor Hough completed her family practice residency in New Jersey last summer. Doctor Hough was to start her medical practice with Roger S Gray, Jr, MD* of Evansville late last summer. Due to a plane crash, she was left partially paralyzed. She toured the Whitewater campus in December and was offered a position there to treat disabled students. ■

News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Dr George Hilliard Community Health Center in Milwaukee has received contract awards of about $90,000 for renovation and construction at the new Center. Work was to have begun in early February and the facility, operated by Deaconess Hospital in an existing building, is expected to open in April. Established through combined federal and Deaconess funding, the outpatient center is a joint undertaking of the hospital and the Inner City Development Project (ICDP). ICDP received a federal grant of $329,316 last December to launch the center and to establish a second clinic later this year on Capitol Drive. That site is to be operated by Mount Sinai Medical Center. Both clinics eventually will be staffed by physicians and dentists employed by the federal government in lieu of military service. Construction, operation, and ancillary services are the responsibilities of the hospitals. The comprehensive, low-cost outpatient programs are designed to serve an estimated 5,000 families in the Inner City of Milwaukee, an area designated by the US Dept of Health, Education, and Welfare as underserved medically.

The Medical College of Wisconsin board of directors has decided to take measures in next year's freshman class to counteract a lid on state financial support to MCW, according to a report in the February 1 issue of *MCWWORLD*. The following actions were approved by the board January 11: (1) a freeze on freshman class size at 200, with the number of Wisconsin residents held to about 50 percent; (2) a sharply increased tuition of $9,500 for new out-of-state residents; (3) a tuition increase of 8.5 percent to reflect inflation for all other students—for Wisconsin residents, an increase from $5,300 to $5,750; for out-of-state residents, an increase from $6,000 to $6,500. The report further said that the action was taken with the understanding that it was not irrevocable if the Governor and Legislature agree to increase the level of financial support. The board also called for negotiations to continue with the State for more aid.

Skemp-Grandview Clinic SC and LaCrosse Clinic Ltd recently announced the consolidation and merger of their medical practices into a single practice—Skemp-Grandview-LaCrosse Clinic Ltd, with its administrative office at 815 South Tenth Street, LaCrosse. Charles L Dawley, formerly the administrator of the Carle Foundation Hospital, Urbana, Illinois, has been named as chief administrative officer of the consolidated corporation. The corporation has six locations—two in LaCrosse, Holmen, West Salem in Wisconsin, and LaCrescent and Houston, Minnesota. ■

Specialty Societies

The Milwaukee Academy of Surgery at a recent meeting, installed Marvin Glicklich, MD,* as its new president. Elected president-elect was Stuart Wilson, MD.* Other MDs elected were Gale L Mendeloff,* secretary-treasurer, and Mark Kiselow, recorder. ■

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MEMBER AMERICAN GEM SOCIETY

Medical Assistants

MARCH 1980

Annual Meeting May 16-18 in Beaver Dam

The Wisconsin Society of the American Association of Medical Assistants, Inc will hold its 25th Annual Meeting May 16, 17, and 18 at the Dark Horse Inn (Hotel Rogers) in Beaver Dam. The Dodge Chapter will host the event. The theme is "One Day at a Time."

The pre-convention Executive Board meeting on Friday, May 16, will precede a luncheon for the delegates. The House of Delegates will meet on Friday afternoon to conduct the business of the Society, elect officers, and update the Constitution.

On Saturday, May 17, the program's main topic will be "Education." President Alma Allen will give the welcome.

The first morning session will cover "Over-the counter Drugs" by Charlotte Anderson Smith, registered pharmacist of the University School of Pharmacy, Madison. The second session will be on "Consumer Affairs, Issues and Answers" by Gary Grimm, Consumer Affairs Assistant of the Wisconsin Department of Agriculture, Trade, and Consumer Protection. Following the President's Luncheon a two-hour session on "Assertiveness Training" will be presented by Valarie A Thibaudeau Graczyk, teacher at Marian College, Fond du Lac.

Continuing Education Units (CEUs) will be given to all participating members who pass the examinations following each presentation.

The formal banquet will be held on Saturday evening with installation of officers. President Allen of Racine will pass the gavel to the new president, Carol Wiesner, CMA of Black Creek. The Valley Chapter will honor the new president with a reception following the banquet. A Sunday morning ecumenical church service will precede the brunch. The report of the House of Delegates meeting will be given and the new president will announce her committees.

—**Mary Ann Banetzke**
Sib Galston
Co-chairmen Annual Meeting. ■

Quinamm™

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

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Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease . . . consider Quinamm . . . simple, convenient dosage—usually just one tablet at bedtime . . . can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.

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Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
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Injection, 300 mg./2 ml.,
in single-dose vials
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WPS

report

for Wisconsin Physicians

Volume IX, Number 2 March 1980

HEALTH INFORMATION FLYERS

In addition to the health information brochures discussed in the January, 1980 *WPS Report*, WPS has developed and has available for distribution several short flyers on health information topics. These flyers are designed to fit in a standard business envelope and are appropriate for patient education activities. Each of these attractively mounted flyers is available to interested physicians, clinics, institutions, organizations, and community groups.

Let's Get the Kids Vaccinated provides guidelines for childhood immunizations against infectious diseases as well as a message of support for childhood immunizations in general. The information contained in the flyer is based on recommendations of the American Academy of Pediatrics Committee on Infectious Diseases.

More Than A Cold: INFLUENZA contains useful, seasonal, information on the prevention, care, and treatment of this annoying, and sometimes serious condition.

The Heimlich Hug is designed to educate the reader on the proper method in performing this valuable technique for assisting choking victims. The text provides complete, step-by-step, easy-to-understand instructions for performing the maneuver on both adults and small children The text is also supported by helpful illustrations. *The Heimlich Hug* comes in two forms--a sturdy wallet-size card and a colorful 8½" x 11" version suitable as a wall poster

Prevent Accidental Poisoning discusses seven commonsense measures to prevent children from gaining access to toxic substances around the home. The text also provides advice on what to do if, despite precautions, accidental poisoning does occur.

Smoking is WPS' most recent health education flyer. By letting overwhelming statistics speak for themselves, the text emphasizes the pronounced health hazards to the individual and the overall costs to society in general associated with smoking.

Up to 25 of these informational flyers can be obtained free from WPS. There will be a nominal charge of 3 cents per flyer for orders of more than 25. Simply request the title and quantity desired from Communications Division, WPS, P.O. Box 8190, Madison, WI 53708.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

RECIPROCITY

There may be times when your office provides service to a patient visiting or on vacation from another state and who is a member of another state's Blue Shield Plan. In some cases, your office is able to send your claim statement directly to WPS for reimbursement, thus shortcutting the time-consuming task of sending your claim to another state for processing.

The Reciprocity System was established in 1971 to give Blue Shield Plans a means of providing Usual, Customary, and Reasonable (UCR) charge coverage for eligible subscribers who receive professional services in another plan area. If a patient is covered under this system, his or her Blue Shield identification card has a double-pointed arrow containing a three-digit number preceded by the letter "N," such as N621

If your office provides services to an out-of-state patient eligible for Reciprocity coverage, simply complete the standard claim form in the usual manner with the following exception. Enter the letter and number in the arrow, along with the patient's policy identification number in the section on the claim form reserved for the identification number. Each plan has a different number. The plan number shows WPS whom to bill in order for WPS to be reimbursed for the reciprocity claim.

After completing the claim, forward it to WPS Blue Shield. To insure that the reciprocity claim is handled quickly and efficiently, it would be helpful if you would make a copy of the patient's Reciprocity Identification Card and attach it to the claim form. Once the claim is processed, WPS will reimburse the physician's office directly at UCR levels for covered services.

The following is a **general** listing of services covered under the Reciprocity System up to $5,000 for the entire claim:

1. Surgery
2. Anesthesia
3. Radiation Therapy
4. Laboratory and Pathology
5. Inhospital Medical Care
6. Benefits for Hospital Admission up to 30 days for TB, Nervous and Mental, Drug Addiction, and Chronic Alcoholism
7. Outpatient Emergency Care
8. Consultations for Hospital Bed Patients
9. Diagnostic X-ray for Hospital Bed Patients or as the result of Accident or Injury.

Because there are some qualifications in this list of covered services, specific questions should be directed to Ms. Judy Wanless at WPS (608-221-4711).

Services which are not on the above list are not covered under Reciprocity and will not be reimbursed by WPS. However, if some services on the claim form are not covered under the program, WPS will pay for any covered services and forward the remaining services to the original Blue Shield Plan for further processing. Therefore, if the claim form combines covered and non-covered services under Reciprocity, many physicians' offices find it most convenient to send the claim to WPS for timely reimbursement for covered charges from WPS and possible later reimbursement by the other plan for the remaining charges Also, if the total charges for the claim exceed $5,000, the claim should be sent to WPS for UCR determination after which WPS will forward it to the Home Plan which then determines reimbursement to be sent to the physician's office. Claims under $5,000 which do not contain any services covered by Reciprocity should be sent directly to the other state's plan for fastest handing.

Reciprocity is a worthwhile national program. However, its features must be understood and utilized by all participants in health care services to keep the program a continued success.

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

Emergency service physicians needed for a 24-hour emergency service in a fully accredited acute care facility located in a beautiful northeastern Wisconsin community. Your off duty time can be filled with year round recreational activities. Excellent salary, malpractice insurance paid. Other attractive fringe benefits. Interested physicians write to: C Vincent Cassiani, Executive Vice-President, Clintonville Community Hospital, 35 North Anne St, Clintonville, Wis 54929 or call collect 715/823-3121. 2-3/80

Family practitioners: To expand central core of primary care physicians in well established southeastern Wisconsin multispecialty clinic. 30 miles from Milwaukee. Excellent recreation area. $45,000 first year salary, with additional incentive plan and many other fringe benefits. Excellent opportunity. Send CV to Recruitment Committee, Burlington Clinic, SC, Box 40, Burlington, Wis 53105. 2-4/80

Family or general practitioner: One or two to serve community of Omro located ten miles west of Oshkosh on Highway 21. Modern, well-equipped facility available with option to buy or lease. Financial assistance available through community organization. Vacancy created by death of community physician. Hospital located 20 minutes away. 330 beds. Practice possibilities are unlimited due to growth of community and surrounding area. Please contact: Elaine Peck, RN, 223 Jackson Ave, PO Box O, Omro, Wis 54963. Tel: 414/685-2228. g5tfn/79

The Wisconsin Veterans Home has an immediate vacancy for a staff physician. Institutional geriatric practice at 700-bed state-operated Veterans Home. Located in an excellent summer and winter recreational area, the Wisconsin Veterans Home offers a challenging medical opportunity with the additional benefits associated with small community living. We offer competitive salary (starting to $63,000); liberal fringe benefits (40% fringe); regular hours, paid malpractice insurance, and other benefits. Contact: John Peters, Personnel Manager, Wisconsin Veterans Home, King, Wis 54946. An Equal Opportunity Employer. 3-7/80

Family Practitioner. Interested in relocating? An excellent family practice setting is available in Green Bay, Wis. Individualized practices, and coverage reciprocity. New 165-bed family practice hospital under construction. Write: Physicians in Family Practice. 120 Siegler St, Green Bay, Wis 54303. Tel: 414/497-0707. 3-4/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Ideal practice opportunities. 50-man multispecialty group with openings for:

- 1-2 Orthopedic Surgeons
- Urologist
- Psychiatrist
- Family Practice
- Neurosurgeon

Prestigious medical group. Perfect location for good family living, 45 minutes from Madison and 90 minutes from Milwaukee. For details contact "Jud" Kindschi, MD, The Monroe Clinic, Monroe, Wis 53566 (Phone collect: 608/328-7000). 3-7/80

Southeastern Wisconsin, General surgeon needed. Thriving city, only an hour from Milwaukee, with a modern 100-bed hospital, need general surgeon for burgeoning practice. Hospital will support: reimburse relocation expenses, guarantee income, provide office. Medical staff endorses need. Call or write: CONSULT-Wisconsin, 305/922-1505. 1940 Harrison St, Mezz, South, Hollywood, Fla 33022. p3/80

Physicians Exchange

continued

Multispecialty Group of 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Dermatologist
- Ophthalmologist
- Family Practitioner

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. Excellent community of 50,000. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

Group Health Cooperative of South Central Wisconsin. A growing federally qualified staff model HMO is recruiting internists, OB/GYN, and family practitioners for July 1980. Excellent salary, pension, and benefit program in an area of natural beauty making living and working here very attractive. Write or call David S Grab, MD, Medical Director, 1 South Park St, Madison, Wis. Phone 608/257-9700. An Equal Opportunity Employer. 1-3/80

Family physician: Appleton, Wis—to join 4 certified ABFP physicians. City of 60,000, economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact K E Buchanan, MD, 620 Longview Dr, Appleton, Wis 54911 or tel: 414/734-7144. 1-3/80

Family practitioner wanted. 13-man, mixed group practice seeking family practitioner to join its Family Practice Department of six family practitioners located 100 miles south of the Twin Cities in a community of 25,000. Ideal community with excellent schools and multiple recreational opportunities, new hospital. Liberal benefits and top salary offered. This is a choice practice opportunity in rural southern Minnesota. Please contact James Burns, MD, 210 N St Mary St, Albert Lee, Minn 56007. Tel: 507/373-1441. pl-4/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Neurologist wanted—Clinical Neurologist wanted to practice in conjunction with a 6-member Internal Medicine Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 470 in care of the Journal. 9tfn/79

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5222 Painted Post Drive
Madison, Wisconsin 53716
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Licensed Employment Agency 9tfn/79

Diagnostic radiologist wanted to join two-man service corporation covering 185-bed hospital and 32-physician clinic. Consideration for early partnership. Contact Jacob M Gerend, MD, 705 Oak Tree Rd, Sheboygan, Wis 53081. Tel: 414/458-0050. 12/79, 1-5/80

The Nicolet Clinic, SC a progressive 33-physician multispecialty group is looking for physicians in the following areas of practice:

- Pediatrics
- Dermatology
- Nephrology
- Family Practice

Modern, state of the art facilities, adjacent to Theda Clark Regional Medical Center and another building located on the Fox River. First-year salary open; full membership after one year. Liberal benefits including qualified Profit-Sharing Plan, and emphasis upon continued education. Outstanding professional and personal life-style opportunities. Excellent recreational area, located on the north end of Lake Winnebago. For more information, send letter and resume in confidence to E E Wilson, MD, Chairman, Recruiting Committee, or D J Anderson, FACMGA, Admin, Nicolet Clinic, SC 411 Lincoln St, Neenah, Wis 54956, or call 414/725-7071. 12/79,1-5/80

Primary care internists and family practitioners wanted, board certified or eligible, for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel: 414/289-5910. 1-6/80

Internist wanted: Board certified or eligible to join (July 1, 1980) nine-physician, multispecialty group of four internists, two pediatricians, two ob/gyn, and general surgeon. Clinic building next to community hospital expanding service area in western Milwaukee metro fringe location; first-year salary with optional second-year corporate stockholder, excellent fringe benefits including pension and profit-sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Tel: 414/673-5745 (Collect) 1tfn/80

Fifty-physician multispecialty clinic in west-central Wisconsin wants allergist, cardiologist (noninvasive), orthopedic surgeon, and family practitioner to do acute medicine. Also family practice openings in nearby satellite offices. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact G E Owen, MD, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5222. 2-5/80

PEDIATRICIAN—To join 5-man department in a multispecialty clinic, practicing general and consultative pediatrics. Northeastern Wisconsin community of 50,000 with referral base 100,000; excellent medical facilities; referral Intensive Care Nursery; progressive lakeside community. Contact G D Reilly, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Tel: 414/725-7071. 2-7/80

Young energetic family practitioner urgently needed to join busy group practice consisting of a surgeon, family practitioner, and an internist. Central Wisconsin town of 10,000 with drawing area of 20,000. Excellent salary first year with many fringe benefits. Full partnership next year. Send Curriculum vitae to Merrill Medical Associates, SC, 716 E Second Street, Merrill, Wis 54452. 2-3/80

Neurologists: Board eligible or certified neurologists sought for practice with busy neurosurgical group. Prefer experience with EEG and EMG. Excellent starting salary and fringe benefits. Contact Dept 472 in care of the Journal. 11tfn/79

Wanted: General Surgeon needed to join group of three Board Certified Family Practitioners. Present surgeon in group retiring after 24 years of excellent established practice. Cumberland is a lovely city of 2000 surrounded by lakes. Six-man clinic adjacent to remodeled 47-bed hospital and new surgical suite. Minneapolis, St Paul, and Eau Claire each 80 miles away. Contract negotiable. Corporate member in one year. Contact D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 2-4-/80

Family practice physician wanted to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Obstetrician/Gynecologists/Family Practitioners. Multispecialty group of 28 physicians is offering practice opportunity to: Obstetrician/Gynecologists to join 4-member department and Family Practitioners to join 8-member department. Attractive income offering and excellent fringe benefits; modern well-equipped clinic building and hospital medical school teaching appointment available. AAAHC accredited facility and CAP accredited laboratory. Satellite practice location also available. Excellent educational system and facilities. Recreational activities, exceptional locally, and your choice outside of area within three hours traveling. Contact J E Hartfield, MD, Medical Director, or F J Wilkus, FACMGMA, Administrator, Olmsted Medical and Surgical Group, PA, 210 9th Street, SE, Rochester, Minn 55901, or call 507/288-3443. 2-4/80

Urologist position available at progressive VA Medical Center located in Michigan's upper peninsula. Board Certified candidates are preferred. The community offers ideal family living in town of 18,000 people with good schools, year-round sportman's area with excellent hunting, fishing, and winter sports. Well equipped 214-bed GM&S medical center offering competitive salary and benefits. Applicants must meet required spoken and written English proficiency. Write: Chief-of-Staff, VA Medical Center, Iron Mountain, Mich 49802 or call: 906/774-3300, ext 227. Allowable moving expenses paid. Equal opportunity employer. 2-4/80

Physician - Family/General Practice. $55,000/yr, 60 hours/week. Practice at a modern medical clinic using standard medical office equipment. Completion of AMA recognized internship; licensable and highly acceptable references are required. Hours: 8:00 am to 4:00 pm, Mon-Fri, no fee charged. An Equal Opportunity Employer. Contact: Mr D E Brezicka, Berlin Memorial Hospital, 225 Memorial Drive, Berlin, Wis 54923. p3/80

Family Practitioners. Rural midwestern community, population 3500 with service area of 8500, seeking two Family Practitioners. Thriving community, self-sufficient with unified community support by physicians. Thirty minutes from State Capital with readily available tertiary medical support. Interested parties should contact Dept 478 in care of the Journal. 3-4/80

Medical Emergency Service Associates (MESA), SC is seeking qualified physicians to staff emergency departments in areas located 50-90 miles northwest of Chicago. MESA offers salary computed up to $84,000 annually, excellent working conditions, flexible scheduling and fringe benefits, plus the opportunity to join a stable, growing corporation dedicated to providing quality emergency medical services. Send your CV or telephone: MESA, 188 Industrial Dr, Suite 316, Elmhurst, Ill 60126; Ms Barten 312/832-4504. MESA would like to be a part of your future. 3/80

Ob-Gyn wanted—To practice in conjunction with a 4-member OB-GYN Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 471 in care of the Journal. 9tfn/79

General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

Emergency Physician needed June-July 1980 to replace vacancy in five physician career oriented group at Madison, Wisconsin's largest emergency service. Great place to work and live. Send CV and will call you. John P Rahm, MD, 6105 Ridgwood Ave, Madison, Wis 53716. 3tfn/80

Family practice, OB-GYN, pediatric and internal medicine positions available with a 16-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 2-5/80

Medical Facilities

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Beautiful medical building for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

Medical suites available in new medical building. Attached parking ramp. Adjacent to major hospital. For details call 414/637-5681, Racine, Wisconsin. 1tfn/80

Family practice available for one or two physicians. Thirty-year established practice of deceased physician. Excellent accredited hospital facilities located in Menomonee Falls, Wisconsin and only 10 miles from Milwaukee County Medical Complex. Area offers good schools and recreational facilities for family. Write to PO Box 307, Menomonee Falls, Wis 53051, or phone 414/251-5655. g12tfn/79

Medical Facilities

continued

Office space available for general or unlimited practice in Elkhorn, Wis. Contact Dept 476 in care of the Journal. 1-3/80*

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Ideal clinic building for sale; virtual shell ready for remodeling; 3000 sq ft all one floor; 1500 sq ft bilevel for office and storage; ample parking in village of 10,000 that needs clinic; in center of Germantown in Milwaukee area. Phone 1-414/255-2910. $150,000. 3/80

Real Estate

Lovely, immaculate 3-bedroom ranch one block off Odana Road at west corner of golf course in Madison (Van Hise/West schools). Terms negotiable: rent with option to buy, buy for tax-shelter, assumable VA mortgage at 11.5% with less closing costs, or land contract with small downpayment. Call 608/222-7951 evenings or weekends. 3/80

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NATIONAL MEDICAL SPECIALTY SOCIETIES

1980 Meeting Dates/Sites

APRIL 11-13: American Academy of Pediatrics, *General Pediatrics,* Lake Tahoe, Nevada.

APRIL 14-18: American Association of Pathologists, Grand Hotel, Anaheim, Calif.

APRIL 16-18: American Academy of Pediatrics, *Allergy/Immunology,* Las Vegas, Nevada.

APRIL 20-25: American Occupational Medical Association, Detroit Plaza Hotel, Detroit, Mich.

APRIL 21-24: American College of Physicians, New Orleans, La. *Basic Aspects of Aging* is main theme. Info: ACP, 4200 Pine St, Philadelphia, Pa 19104 (Phone 215/243-1200 or TWX 710 670 0586 or toll-free 800/523-1546).

APRIL 28-MAY 2: American Pediatric Society, Convention Center, San Antonio, Tex.

MAY 3-9: American Psychiatric Association, Hilton Hotel, San Francisco, Calif.

MAY 5-8: American College of Obstetricians and Gynecologists, New Orleans, La.

MAY 8-10: American Academy of Pediatrics, *General Pediatrics #3,* Hilton Head, South Carolina.

MAY 9-13: American College of Cardiology, Houston, Tex. Info: W D Nelligan, 9111 Old Georgetown Rd, Bethesda, MD 20014.

MAY 15-18: American Society of Internal Medicine, Hyatt Regency, Washington, DC.

MAY 18-22: American Urological Association, Hilton Hotel, San Francisco, Calif. (Annual Meeting)

MAY 23-25: American Academy of Pediatrics, *Infectious Diseases,* St Louis, Mo.

JUNE 6-8: American Academy of Pediatrics, *Aches, Pains and Arthritis in Children,* Los Angeles, Calif.

JUNE 20-22: American Academy of Pediatrics, *General Pediatrics #4,* Kiawah Island, South Carolina. Info: Judy C Hambourger, Coordinator for Continuing Education, AAP, PO Box 1034, Evanston, Ill. 60204.

SEPTEMBER 15-18: American College of Emergency Physicians, Scientific Assembly, Las Vegas, Nev. Info: ACEP, 3900 Capital City Blvd, Lansing, Mich 48906; or Fred B Towns (517/321-7911).

NOVEMBER 2-7: Annual Meeting, American Academy of Ophthalmology, McCormick Place, Chicago, Illinois. (Relocated from New Orleans to accommodate increasing attendance.) Info: AAO, 1833 Fillmore St, PO Box 7424, San Francisco, CA 94120, or call 415/921-4700.

DECEMBER 6-11: American Academy of Dermatology, New York, NY. Info: AAD, Inc, 820 Davis St, Evanston, Ill 60201 (Phone 312/869-3954).

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

1980 Wisconsin

APRIL 11-12: Wisconsin Running Weekend, sponsored by the State Medical Society of Wisconsin and the Madison Marathon Association. See details in the ORGANIZATIONAL section of this issue.

APRIL 17-18: *Third Annual St Mary's Symposium on Burns and Critical Care.* Presented by St Mary's Hospital Burn Center, Milwaukee. Format: Combination of didactic lectures and workshops, separate and combined sessions for nurses and physicians. Cochairmen: Burton A Waisbren, MD and George E Collentine, MD. Info: St Mary's Burn Symposium, 2323 N Lake Drive, Milwaukee, Wis 53211.

APRIL 19-20: *Therapeutics 1980,* University of Wisconsin Clinical Science Center, Madison. Fee: $110. Approved 9 credit hours in Category I for PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

APRIL 26: *Bladder Cancer Update 1980.* Twelfth Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee. See further details elsewhere in this section.

APRIL 28-30: *A Seminar-Workshop on Arthrography and Skeletal Trauma,* The Sheraton Inn, Madison. Fee: $250 seminars and workshops; $200 seminars only. 21 hours Category I of AMA, American College of Radiology applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

MAY 2-3: *Vascular Surgery Symposium,* The Wisconsin Center, Madison. Fee: $145. Approved 12 credit hours in Category 1 for PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

MAY 2-3: Wisconsin Urological Society Annual Meeting, Edgewater Hotel, Madison.

MAY 17-18: Workshop on Practice Management, Red Carpet Inn, Milwaukee. 11½ hours AAFP and AMA Category I credit. Info: AAFP, 1740 West 92nd St, Kansas City, MO 64114.

MAY 23: University of Wisconsin Medical Alumni Day, Madison.

MAY 30: *The Family in Primary Care,* Wisconsin Center, Madison. Fee: $50. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

JUNE 11-14: *Cardiac Rehabilitation: Critical Issues and Practical Concerns,* Red Carpet Inn, Milwaukee. Eligible for AMA Category I credit; UW-Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

SPRING PROFESSIONAL INSTITUTE
Presented by Psychiatry Clinic
Friday, April 18, 25, and May 2
Mount Sinai Medical Center
Milwaukee, Wisconsin

April 18: *The Behaviorally Disturbed Mentally Retarded,* presented by Bruce Bell, MS; Bella H Selan, MS; Mary K Madsen, RN, MS, Susan Barksdale, ACSW, et al

April 25: *Treating The Mentally Impaired Elderly,* presented by Barbara Silverstone, DSW, Carole Gold, MSSW, et al

May 2: *Eating Disorders—Anorexia Nervosa and Bulimarexia,* presented by Marlene Boskind White, PhD; Rita Hansen, MD; Lois Rollman, MSW et al

All workshops are geared to physicians, psychologists, nurses, and social workers involved in active treatment situations. Info: Mrs Bella H Selan, MS, Psychiatry Clinic, Mount Sinai Medical Center, PO Box 342, Milwaukee, Wis 53201. Tel: 414/289-8150.

1980 Wisconsin

continued

JUNE 26-28: Wisconsin Academy of Family Physicians Annual Scientific Assembly and Congress of Delegates, Chula Vista Resort, Wisconsin Dells, Wis. Info: WAFP, 850 Elm Grove Rd, Elm Grove, Wis 53122.

Jun 12-13: *Neurosurgical Intensive Care Symposium,* Inn On The Park, Madison. Fee: Physician, $110; Nurse, Resident, $60; Physician/Nurse Team, $140. Info: Contact Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

JUNE 19-20: *Symposium on the Diabetic Pregnancy and the Infant of the Diabetic Mother,* Wisconsin Center, Madison. Fee: $130. 12 credit hours of PRA-AMA Category I. AAFP prescribed credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

JUNE 23-25: Symposium on *Complications in Vascular Surgery,* cosponsored by the Division of Surgery of the Medical College of Wisconsin and the Council on Cardiovascular Surgery of the American Heart Association, at the MCW in Milwaukee.

JUNE 25-27: First Annual Madison Clinical Conference with this year's theme: *Therapeutic Advances in Infectious Disease.* Presented by Extension Services in Pharmacy in cooperation with the School of Pharmacy and the Clinical Pharmacology Section (Department of Medicine), University of Wisconsin-Madison. Conference will explore the following subject areas: (1) selected areas of infectious disease, (2) quality assurance and drug utilization review, and (3) research methods and funding sources. Program has a dual appeal to both clinical pharmacists and infectious disease physicians; attendees should benefit from the interaction provided by this interdisciplinary approach. Acceptable for 15 credit hours in Category 1 for the PRA-AMA. Deadline for registration is April 24. Info: Alan L Hanson, PhD, Extension Services in Pharmacy, School of Pharmacy, 425 North Charter St, Madison, Wis 53706, or call 608/262-3130.

JULY 20-26: *Fifth Annual Wellness Promotion Strategies,* University of Wisconsin-Stevens Point. Limited enrollment. Info: WELLNESS PROMO V, Fred Leafgren, Student Life-Delzell Hall, University of Wisconsin, Stevens Point, Wis 54481. Phone 715/346-4194 or 715/346-2611.

OCTOBER 15-17: *The Sociopath 1980: A Practical Inquiry,* symposium and workshop addressing the problems of the community, the cop, the court, the classroom, and the clinician. Sponsored by the University of Wisconsin and the Mendota Mental Health Institute. Info: Bernadine Eve Bednarz, MSW (phone 608/263-4431) or write UW-Extension, 414 Lowell Hall, 610 Langdon St, Madison, Wis 53706.

CURRENT ISSUES IN MEDICINE

A Health Science Telephone Conference for physicians

Sponsored by State Medical Society of Wisconsin and its Commission on Continuing Medical Education
and
University of Wisconsin-Extension
Dept of Continuing Medical Education

Two lectures remaining—

APRIL 16: *Legislative Wrap-up 1979-80.* A review of significant pieces of legislation introduced and passed in the 1979-80 legislative session, and their implications on healthcare in Wisconsin.

MAY 14: *State Regulations: The Administrative Rule Process.* An overview of the authority and process for developing administrative rules in Wisconsin, including an examination of specific administrative rules such as certificate-of-need and decertification, and their impact on the healthcare system.

Presented on Wednesday morning
from 7:30 to 8:30.

AMA Category I credit available.

If not registered for the series of eight programs by the September 26, 1979 deadline, registrations may be available from UW-Extension, Dept of Continuing Medical Education, Room 456 WARF Building, 610 Walnut St, Madison, Wis 53706.

For a list of 1979-80 ETN hospital locations contact Bill Wendle at SMS offices (608/257-6781 or 800/362-9080) or Ann Bailey at UW-Extension (608/263-2860).

1980 Neighboring

MAY 22-23: *Health Care in the Elderly,* Third Annual Meeting. Sponsored by University of Iowa Departments of Family Practice and Internal Medicine and Iowa Gerontology Project. Two-day meeting of varied presentations of many aspects of geriatric medicine. AMA Category I, 15.5 hours. Info: Ian M Smith, MD, Dept of Internal Medicine, University of Iowa Hospitals, Iowa City, Iowa 52242 (Phone: 319/356-2727).

g3-4/80

Twelfth Annual

Southeastern Wisconsin Cancer Conference

BLADDER CANCER UPDATE 1980

Saturday, April 26

Pfister Hotel, Milwaukee

8:00 am - 12:30 pm

Faculty: Alan B Fidler, MD, Chairman, Planning Committee; Irving J Selikoff, MD, Mt Sinai School of Medicine, New York City; F K Mostofi, MD, Armed Forces Institute of Pathology, Washington, DC; Harry Grabstald, MD, University of Florida, Gainesville; Morris Wizenberg, MD, University Hospital and Clinics, Oklahoma City; and Mark S Soloway, MD, University of Tennessee, Memphis.

No registration fee. Preregistration reservations should be mailed to: American Cancer Society, 6401 West Capitol Drive, Milwaukee, Wis 53216.

Through cosponsorship by the Medical College of Wisconsin, three hours of AMA Category I credits can be earned through attendance. Also, three hours of Elective credit by the American Academy of Family Physicians can be obtained.

JULY 9-10: Eighth Annual Breastfeeding Seminar for Physicians, sponsored by La Leche League International, Sheraton O'Hare, Rosemont, Illinois. 10 credit hours in Category I of the PRA of the AMA.

OCTOBER 9-11: *American Cancer Society National Conference, Gynecologic Cancer*—1980. Los Angeles Hilton, Los Angeles, Calif. Approved 16 hours prescribed credit AAFP and Category 1 of the AMA-PRA. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference—Gynecologic Cancer—1980, 777 Third Ave, New York, NY 10017.

g2/80

1980 Others

APRIL 27: American College of Utilization Review Physicians, Illinois Regional Seminar, Drake Hotel, Oakbrook, Illinois. Theme: *Future of PSRO in the 80s.* Speakers selected will offer expert insights and appraisals of what the future holds for physicians and healthcare facilities during the 80s. Since healthcare delivery participants and facilities will be subject to continuing and increased surveillance during the next decade, this program will present an overview to help the physician prepare himself to meet these challenges and upgrade his skills as the leader in the practice-oriented approach to Quality Assurance, Utilization Review, and Cost Containment. Participants will be awarded Category I credit hours. Speakers: Mr Robert Goodenow, Director of PSRO-Region 5, DHEW; Melody Drew, Quality Assurance Coordinator, St Joseph's Hospital, Chicago; and Charles Jacobs, JD, invited, President, Interqual. Info: Eugene V Handelman, MD, Chapter President, ACURP National Office, 1108 North Second Street, Harrisburg, Pa, 17102.

SUMMER 1980: National Endowment for the Humanities, eight seminars for physicians, nurses, and other healthcare professionals, starting July 7 through August 29. Purpose is to advance public understanding and use of the humanities by giving professional leaders the opportunity to stand back from their work and explore a wide range of issues of national concern under the direction of scholars in the humanities. From 12 to 15 persons attend each month-long seminar tuition-free, receiving a stipend of $1,200 plus reimbursement for travel. Application deadline is April 14. Info: Professions Program, Fellowships Division MS-101, National Endowment for the Humanities, Washington, DC 20506.

NUCLEAR CARDIOLOGY FOR THE PRACTICING PHYSICIAN

Third Annual Symposium arranged by Dr Harold L Brooks and Dr Jagmeet S Soin at the Medical College of Wisconsin

July 27—July 30, 1980

The Hilton Head Inn at Sea Pines Plantation, Hilton Head Island, South Carolina

Course is designed to bring the state of the art in Nuclear Cardiology to the practicing physician in community hospitals throughout the nation, specifically to physicians specializing in nuclear medicine, cardiology, and residents, fellows, and technologists. Program will consist of lectures, detailed panel discussions with audience participation and on-site demonstrations of current equipment.

For information contact—

Dr Jagmeet S Soin, Division of Nuclear Medicine, Milwaukee County Medical Complex, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

1980 AMA

APRIL 17-18: AMA 33rd National Conference on Rural Health, Boston, Mass. See details elsewhere in this section.

APRIL 18-19: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Cherry Hill, New Jersey. See details elsewhere in this section.

JUNE 12-14: *AMA Seminar on Knowledge and Skill Development in Negotiations.* Burlingame, Calif. See details elsewhere in this section.

JULY 20-24: AMA Annual Meeting, Marriott, Chicago, Ill. Info: AMA, 535 North Dearborn St, Chicago, Ill 60610.

SEPTEMBER 12-13: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Kansas City, Mo. See details elsewhere in this section.

AMA Department of Negotiations presents

SEMINARS ON KNOWLEDGE AND SKILL DEVELOPMENT IN NEGOTIATIONS

April 18-19, 1980/Cherry Hill, New Jersey

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution for Hospital, HMO, Academic and Other Salaried Physicians.* Cherry Hill Holiday Inn.

September 12-13, 1980/Kansas City, Missouri

Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution with Health Planning and Other Government Agencies.* Radisson-Muehlebach Hotel.

June 12-14, 1980/Burlingame, California

Advanced seminar for physician negotiators: *Dynamics of Conflict Resolution.* Burlingame Hyatt House. (near San Francisco International Airport)

As an organization accredited for continuing medical education, the AMA Council on Continuing Physician Education certifies that the continuing medical education activities designated Category I meet the criteria for Category 1 on an hour-for-hour basis for the Physician's Recognition Award of the American Medical Association.

For more information on above educational programs, contact **AMA Department of Negotiations, 535 North Dearborn St, Chicago, Illinois 60610, or call 312/751-6652.**

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

FILM ON CPT-4 AVAILABLE TO COUNTY MEDICAL SOCIETIES. The American Medical Association, through a grant from the Control Data Corporation, has developed a 17-minute orientation film on Current Procedural Terminology, Fourth Edition (CPT-4). The film is intended for showing at county medical society and specialty society meetings for physicians and other interested parties, and is available free of charge on a loan basis. Brochures describing CPT-4 can be supplied upon request for distribution at film showings. CPT-4 is a publication which lists descriptive terms and identifying codes in order to provide uniform reporting of medical procedures and services by physicians and third-party payors. For further information on obtaining the film contact Jean McKeag, Dept of Applied Medical Systems, AMA Headquarters, 312/751-6781.

WHCLIP PREMIUMS CAN BE PAID TO PETER WOOD, AGENT. If you are one of the many physicians who obtain their professional liability coverage from the Wisconsin Liability Insurance Plan (WHCLIP), and you complete your own application and renewals, SMS Services, Inc encourages you to designate one of its staff members, Peter Wood, as agent for your WHCLIP policy. WHCLIP pays a commission of $125 each year to the insurance agent designated by the policy holder. *(The existing agency representation for your other business and personal insurance policies should be preserved).* The amount of premium which you pay is not reduced if you do not name an insurance agent. Instead, the $125 is simply retained in WHCLIP general funds. Mr Wood is a licensed insurance intermediary who will keep you informed as to premium changes, due dates, and other aspects of your WHCLIP coverage. He has assigned all commissions he may receive from WHCLIP to SMS Services, Inc, a wholly owned affiliate of the State Medical Society. SMS Services, Inc works with SMS to help keep SMS members informed on WHCLIP and other important liability matters, and to help protect the interests of both doctors and patients on malpractice issues.

PHYSICIANS ADVISED TO WATCH OUT FOR CONFUSING SOLICITATIONS. Physicians nationwide are being solicited by a Miami, Florida firm called US Directory Service to pay $20 to "participate" in a medical directory listing. Physicians should not confuse the Miami solicitation with the American Medical Association's *American Medical Directory* which is published by the AMA and lists all US physicians. The matter currently is being investigated by postal authorities. ■

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WISCONSIN MEDICAL JOURNAL

APRIL 1980

• The new president: Russell F Lewis, MD • Doctor Motzel to head SMS next year • Council updated on antitrust and organized medicine issue • Palliative radiotherapy/Doctors Bosch and Caldwell • Wisconsin Neurological Society abstracts • Medical Society points out flaws in Health Plan

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*Present as 345.9 mg. and 691.8 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. and 600 mg. fenoprofen respectively.

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WDS
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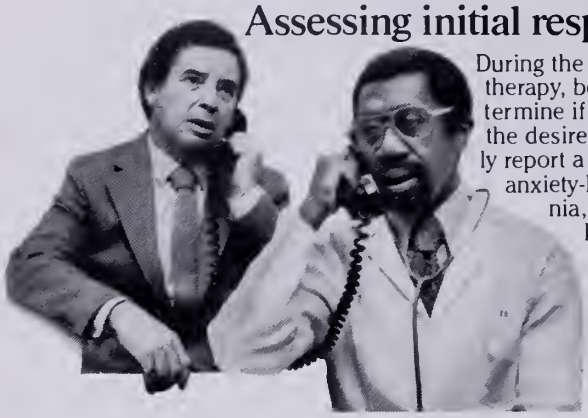
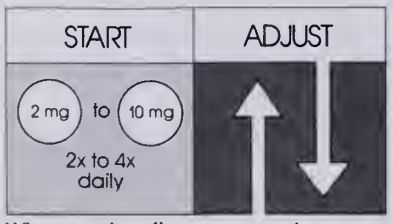
Monitoring patient response to Valium® (diazepam/Roche)



Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.

Making dosage adjustments



With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

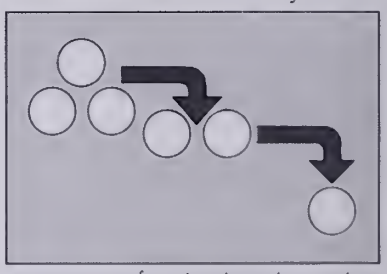
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention

When you decide to discontinue therapy, tapering do is good medical pra Although rarely necessary after short-te treatment with Valiu gradual dosage redu is advisable for pati who have been on e tended therapy. This ual discontinuance should preclude eit recurrence of pretreatment symptoms or development of toward side effects. Symptoms of withdrawal have almos ways been associated with abrupt discontinuance of ther higher dosages taken continuously over long periods of ti



2-mg, 5-mg, 10-mg scored tablets

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diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety

ROCHE®

See the following page for a summary of product information.

Valium® (diazepam/Roche) ®

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500. Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

Only 17—unlicensed doctors

Without acrimony or critical comment and without retrospective remarks relative to the governmental misjudgment regarding required CME, the total number of unlicensed doctors is now down to 17.

In December there were reports that 1000 Wisconsin physicians plus another 800 who were licensed in Wisconsin but not practicing in the state would not have their licenses renewed January 1, 1980 because they failed to certify fulfillment of the CME requirement. At that time a state official was quoted as saying that, "Well, I suppose they (Wisconsin physicians) are all going to be off on vacation in January and nobody dare get sick."

Later the list was downgraded to 650 physicians. Finally, when the red tape was untangled and the deceased and retired physicians and those who had moved to other states were removed from the list, the total number of physicians who might be unfrocked had been reduced to 17 names.

Meanwhile, the controversy about the methods and value of accumulating a given number of Brownie points annually continues to rage.—VSF

Dear Ms Jones:

I am writing on behalf of my patients and colleagues because of what I consider an alarming trend in your profession. When I first began dealing with patients as a house officer, I was impressed with the role the hospital nurse played in the total healthcare scheme. Under the supervision of the attending physician and within the scope of the doctor's orders, she saw to the patient's well-being and comfort on a simple person-to-person basis twenty-four hours a day. It was an efficient, satisfying, uncomplicated relationship. But then gradually changes occurred that took the nurse away from the patient's bedside and put her at a desk behind a stack of charts or in various conference or planning rooms most of the working day. She began to take courses in psychology, sociology, and counselling. And she began to lose sight of the motives that steered her into the nursing profession in the first place.

And perhaps most symbolic of all, she stopped thinking in terms of patients as *patients.* They became *clients.*

"Client" is a perfectly good word, but it implies a business arrangement rather than the almost spiritual connotation depicted in the nurse-*patient* relationship.

The fact is, you have begun to treat your patients like *clients,* and that's what I find most alarming.

You have begun to see your role as that of an independent practitioner—as an equal of the physician in the healthcare system.

I have always believed that the nurse on the general medical or surgical floor is there to care for the patient under a doctor's supervision and to be alert for changes of which the doctor should be made aware. I have never perceived the hospital nurse to be an independent practitioner with complete freedom to tell my patient whatever she wishes about the operation I am going to perform and the consequences thereof without first clearing it with me. Nor do I consider her qualified to discuss prognosis or ignore orders with which she might disagree.

You say times have changed, that today's nurse is better educated, and I agree. You say that she is a trained professional capable of making informed decisions. Again I agree, but those informed decisions can only be *nursing* decisions. Until she graduates from medical school and becomes licensed to practice medicine, she cannot make *doctor* decisions.

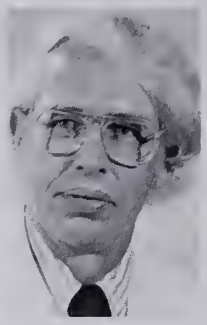
Nurses have important roles to play, but what they must do is focus a little more sharply on what their role actually is. When that is done, my colleagues and my patients will appreciate them all the more.—WJB

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Palliative Radiotherapy

In this issue is a thoughtful, philosophical article. It is entitled "Palliative Radiotherapy in the Patient with Metastatic and Advanced Incurable Cancer."

In submitting it, Doctor Antonio Bosch, who is a Professor of Human Oncology and Radiology at the Wisconsin Clinical Cancer Center, wrote the following note: "This article is the last written in collaboration with Doctor William Caldwell, who devoted his life to the field of Radiotherapy and to Oncology in general, who contributed greatly to the management of cancer in Wisconsin, and who always maintained a high regard for the patient's welfare."



Doctor Caldwell

As one of the Editorial Board members commented, "This is a rational and realistic approach to a perplexing, agonizing problem. It is a great tribute to a dedicated physician in a difficult field."

Doctor Caldwell's tragic and untimely death was a great loss to the staff at the Wisconsin Clinical Cancer Center, to the physicians of Wisconsin, and particularly to the patients with malignancies to whom he was so dedicated.—VSF

CONTRIBUTIONS CES FOUNDATION FEBRUARY 1979

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for February 1979.

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William D James, MD: 1908-1980

Doctor Bill James, in his later years, could easily have looked upon his participation in county and state society and felt he had contributed very measurably to the future of the medical profession in Wisconsin. Indeed, he had done so. Yet, he always felt he could do more.

Doctor James

Bill became a councilor of his medical district midst controversy and divisiveness among doctor factions. He brought his colleagues into an era of peace and solidarity.

He prompted the Society in 1969, when he was President, to host a statewide conference on health care costs with a select group from business, labor, government, and the "consumer" community (in those days the word was used in quotes!). He called upon then Governor Knowles to use the Society's knowledge and cooperation in building a better but more economic Medicaid program.

Bill's life was full of expectation, dedication. University of Wisconsin President Conrad Elvehjem once said . . . "Give us the mountains to climb, and the vision to climb them." Doctor James had them both. And when he died on February 21, he had truly seen the view from the top.—ERT ■

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Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Appropriateness review

I appreciate the efforts made by the SMS to more actively involve physicians in health planning and to provide them with the information they need to do so. The NEWS YOU CAN USE feature appearing on page 9 of the February 1980 issue of the *Wisconsin Medical Journal* seems to be a useful attempt along these lines.

It seems reasonable, however, to point out the definition of Appropriateness Review included in that feature is, if not, inaccurate at least misleading. The *Wisconsin Medical Journal* is correct saying Health Systems Agencies (HSAs) and the Wisconsin Department of Health and Social Services are required by law to review the appropriateness of at least those institutional health services addressed in the State Health Plan.

The *Wisconsin Medical Journal* is misleading, however, when it states "the State may impose sanctions" on services found to be inappropriate. There is **nothing** in the Federal legislation or regulations that asks, requires, directs or suggests the imposition of such sanctions. Neither is there any existing or currently proposed State mechanism which would permit the imposition of such sanctions. If such a mechanism were to be developed (and no one is currently thinking of doing so as far as I know), it would require State legislative action for either the development of new regulations or passage of new legislation.

At the present time, the HSA and State staff (myself included) who have been meeting on appropriateness review have expressed several tentative opinions. First, appropriateness review will probably not be a separate, free-standing function, but will be incorporated in the present plan development activities currently being carried out. Second, sanctions are **not** being proposed. Third, the agencies will continue to seek broad input in the development of their plan sections.

I hope this information is of some interest to the *Wisconsin Medical Journal's* readers.

—**John F Grabowski**
Associate Director
North Central Area Health
Planning Association, Inc

• • •

Editor's note: We disagree with Mr Grabowski's assertion that there is nothing in the Federal Legislation or regulations that asks, requires, directs, or suggests the imposition of sanctions on services found to be inappropriate. To the contrary the summary of the rules and regulations for appropriateness review found in the *Federal Register* (Vol 44, No 239, December 11, 1979) states that while the House Committee on Interstate and Foreign Commerce "has not required any sanction related to these (appropriateness) reviews which would require that unneeded existing institutional health services be eliminated or closed . . . if a state were to decide on its own initiative to create such a sanction, the Committee would of course have no objection to this." This clearly shows that sanctions are not required, but neither are they prohibited. The State Medical Society of Wisconsin has a responsibility to inform its members of **all** possibilities contained in the law with regard to appropriateness review.

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Physician advertising

Governor Jerry Brown of California has signed legislation permitting healthcare professionals to advertise their fees and services (*Wisconsin Medical Journal,* October 1979). This move was apparently instigated by the edict of E G Barnes, an administrative law judge for the Federal Trade Commission who recently ruled that the AMA's Code of Ethics illegally restrains competition among doctors by preventing them from advertising, resulting in price-fixing, and depriving patients of the information they need in selecting a doctor. In order for Wisconsin physicians to stay

within the law, and also to keep them abreast of their California competitors, I am submitting the following sample ad:

Cut rate surgery / prices slashed

Once in a lifetime bargains

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Right bronchus	$ 30.00
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We give Green Stamps

The Glorious People's Clinic

—**R W Steube, MD**
Naples, Florida

Fibrinogen I^{125} leg scanning

An abstract in the *Wisconsin Medical Journal* of October 1979, Volume 78, entitled "The Limited Utility of Fibrinogen I^{125} Leg Scanning," is an example of misinterpretations that can occur with statements taken out of context. The abstract is from an article in the *Archives of Internal Medicine* 139:148-153, February, 1979. A careful survey of the article itself reveals that the study population did, in fact, include 150 patients; however, 104 of these were eliminated because of poor venography or unilateral venography and the total qualifying for comparison was 46 which is slightly over 30%. In other words, 70% of the patients were eliminated and yet supposedly valid conclusions were offered. Statements of sensitivity and specificity should not be confused with statements concerning percent of accuracy. The entire article should be reviewed in depth, particularly as it related to other investigators who have found I^{125} fibrinogen an accurate screening procedure.

It is also interesting to note that in the same issue of the *Archives of Internal Medicine* an editorial by F William Blaisdell, MD from the University of California is quite critical of the article itself and states "that it is valuable in that it tempers enthusiasm for mass screening of patients" but "does not necessarily refute the accuracy of previous reports."

I have written a critique of the original article as it appeared in the *Archives of Internal Medicine* and have been informed by the editor of that journal that it will be printed in their correspondence in a future journal.

I think that it would be most unfortunate if members of our profession who read and did not dissect the original article and who read the present abstract accept the statements and do not give I^{125} fibrinogen a fair trial, particularly in view of the extensive favorable reports that have been made available for the past several years from both British and Americans using the procedure.

—**Leo Stockland, MD**
Milwaukee, Wisconsin

• • •

Editor's note: The abstract was not taken out of context; it was prepared by the primary author. Doctor Stockland's critique of the original article, as mentioned above, has now been published in the February 1980 issue of *Archives of Internal Medicine*, vol 140, pp 285-286, along with another critique by Behram Pastakia, MB and A A MacKinney Jr, MD of Madison, Wisconsin, and a reply to these two critiques by the primary author of the original article, Richard D Sautter, MD of Marshfield, Wisconsin. Excerpts of Doctor Stockland's critique and Doctor Sautter's reply are reprinted below with permission from the *Archives*.

To the Editor—The sine qua non of a deep venous thrombosis according to this investigation is the venogram. Since it assumes that a normal venogram rules out the presence of a clot, any other study that indicates that there is a clot is automatically designated as a false-positive. Since specificity is a true-negative divided by the sum of a true-negative and a false-positive, specificity is based on a study that may in fact be in error. In the absence of any false-positives, specificity as indicated here would be 100%.

Sensitivity is designated as a true-positive divided by the sum of a true-positive and a false-negative, again based on the assumption that a venogram is the standard. In the absence of any false-negatives, sensitivity would be 100%.

It is generally accepted that there are limitations to venography and that failure to demonstrate a clot does not mean that there is no clot proliferation.

Conversely, demonstration of a clot does not indicate whether it is acute or chronic. Extensive studies indicated that fibrinogen I 125 scanning is ineffective in detecting old thrombi because they do not take up fibrinogen. To our knowledge, the identification of thrombi or occlusion by venography is such that there are no radiographic characteristics of an acute vs an old thrombus. It would, therefore, be impossible to determine whether a thrombus found by venography ten days after surgery was concurrent with that surgical procedure or, in fact, existed before it. The only proof of this would depend on preoperative venography followed by postoperative venography.

This article did not mention therapy, and it is not indicated whether patients were heparinized following positive fibrinogen I 125 test results, which were followed by venograms about four days later, or whether no therapy was used at any time. Importance of the

detection of thrombi ten days after normal leg scanning was not evaluated nor was treatment outlined . . .

At no point was the ultimate concern of deep venous thrombi (pulmonary emboli) mentioned or evaluated. Lung scanning was apparently not done in any way in conjunction with the fibrinogen I 125 studies, nor in conjunction with the venography. There are studies indicating that venography can dislodge thrombi and produce emboli, and that the irritation of the radiopaque material might be the cause of deep-vein thrombi. There were no follow-up examinations using fibrinogen I 125 scanning after the venography to evaluate these possibilities.

It was stated that "because of the small number of thrombi present in this area, the chance of leg scanning to be falsely negative was small, accounting for the high negative accuracy." The implication is that the number of cases was low, but that the statistical significance was more pronounced. This is inconsistent with the fact that only 30% of the patients were evaluated with venography. It is stated that it is impossible to detect all false-negative leg scan results without routine confirmation by venography and that scanning should never be used as an exclusion test because of the high number of false-negative results. Since 50% of deep venous thrombi are asymptomatic and there are many atypical signs and symptoms of pulmonary artery emboli, discouraging the use of fibrinogen I 125 scanning as a screening test is a disservice.

In the absence of clinical signs or symptoms of deep venous thrombi, the statement that "leg scanning should never be used as an exclusion test . . ." implies the use of venography routinely. This is untenable.

Studies by reliable groups with apparent valid correlation indicate that I 125 fibrinogen leg scanning is approximately 85% to 90% accurate. There is little in medicine and/or even the basic sciences that does not allow for approximately 10% of error. This degree of accuracy is felt to be such that the examination is a valid screening test that may, in some cases, be further verified by impedance and/or Doppler studies . . .

LEO STOCKLAND, MD
Milwaukee, Wisconsin

In Reply.—The letter from Drs Pastakia and MacKinney is well taken. Certainly, we would welcome any new alternatives to fibrinogen I 125 scanning as a screening procedure for the detection of deep venous thrombosis. I hope, however, that these new radioisotopes (iodine 123, with a 159-keV γ-ray; scintigraphy with technetium 99m-labeled RBCs or fibrinogen and indium 111-labeled platelets) would be subjected to the same trials reported in our article, to determine whether or not they are, indeed, offering a more accurate screening test.

I believe some of the difficulties clinicians have had with fibrinogen I 125 leg scanning are attributable to the fact that a radioisotope is being used; some clinicians compare it to pulmonary scintillation scanning. I think there is general agreement that if pulmonary scintillation scanning results are negative, the possibility of embolization is virtually nil. The unconscious transfer of this concept to leg scanning is very dangerous because the sensitivity of leg scanning is so low that one may be lulled into a false sense of security, thinking no thrombus is forming when one is present.

With respect to the comments made by Dr Stockland, the evaluation of any screening test is contingent on the use of a more definitive method of detection. That is, one must define a reference procedure such as venography to evaluate a screening procedure such as fibrinogen scanning. Dr Stockland would have the reader believe that the problems of using venography as a criterion for evaluation are severe enough to render venography unsuitable as a reference procedure. He challenges the adequacy of venography on two grounds; first he states that "it is generally accepted that there are limitations to venography and that failure to demonstrate a clot does not mean that there is no clot proliferation." These limitations alluded to by Dr Stockland involve the inability of venography to adequately visualize all segments of the deep venous system. As we indicated in our study, we were also concerned about this limitation of venographic performance. Because of this concern, we decided to use only those anatomic areas where the venogram demonstrated complete visualization of all segments of the deep venous system for comparison. Inadequate visualization was primarily in the region below the origin of the popliteal vein. Venographic performance above this region was excellent, with inadequate visualization occurring in only four of 584 areas. It is in this region, above the origin of the popliteal vein, that thrombi take on greater clinical importance because of the increased propensity for embolization. Indeed, there is still some controversy as to whether or not thrombi detected below the origin of the popliteal vein require anticoagulant therapy.

Dr Stockland's second concern was that "demonstration of a clot does not indicate whether it is acute or chronic. Extensive studies indicated that fibrinogen I 125 is ineffective in detecting old thrombi because they do not take up fibrinogen." The point that Dr Stockland makes is that the poor sensitivity reported in our study was artifactual because of the presence of thrombi prior to the operative procedure. The chance of this occurrence creating a substantial bias in the study is extremely unlikely. Our critic would have the reader believe that there is a very high incidence of deep venous thrombosis in the patient population undergoing elective total hip replacement. The vast majority of these patients are ambulatory and have no previous history of thrombotic disease and, certainly, no acute signs of symptoms of such disease prior to the operative procedure. Of even more importance, all patients underwent fibrinogen I 125 leg scanning the day prior to surgery and in less than 2% was there any indication of the presence of an acute deep venous thrombosis. I would like to remind Dr Stockland that only 14 of the 48 venographically demonstrated thrombi were accurately detected by fibrinogen scan-

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ning above the origin of the popliteal vein. It is completely unreasonable to suggest that a large percentage of the 34 emboli undetected by fibrinogen scanning could have been old thrombi. Dr Stockland contends that the only way to prove if a thrombus found by venography ten days following surgery occurred after the surgical procedure or existed before the procedure is to perform preoperative venography followed by postoperative venography. This contention contradicts his earlier skepticism that "The sine qua non of a deep venous thrombosis . . . is the venogram." We find little logic in this reasoning.

Dr Stockland's difficulty in understanding the study's emphasis and methodology apparently led to other misconceptions on his part regarding the population bases used in the evaluation. As explained in the text, the fact that only 46 of 150 patients were eligible for comparison when both extremities were considered as a single anatomic unit was a result of inadequate venographic demonstration of the venous plexus below the origin of the popliteal vein. When the evaluation focused on the anatomic areas where thrombus formation is of most concern to clinicians, close to 97% (580 of 600) of all possible areas were evaluated (16 of the 20 areas excluded were a result of the fact that venography was done unilaterally in eight patients).

Our statement, "because of the small number of thrombi present in this area, the chance of leg scanning to be falsely negative was small, accounting for the high negative accuracy," was misunderstood by Dr Stockland. The statement was presented in the text to inform the reader that positive or negative accuracy figures are dependent on the prevalence of the items screened in the populations. This has implications for cross-study comparisons, particularly those comparing surgical and nonsurgical populations. The reference referred to the prevalence of thrombi in the region from Hunter's canal to the inguinal ligament where 97% (291 of 300) of all such regions were evaluated. It did not refer to an area where "only 30% of the patients were evaluated with venography," as Dr Stockland suggests.

Dr Stockland, again, appears to be in a state of confusion concerning our recommendations relative to the utility of fibrinogen I 125 leg scanning. Our interpretation of the results presented in this study was that leg scanning should never be used as an exclusion test and that it would be inappropriate to use leg scanning as a confirmatory test. Its utility as a screening test is limited because of the high number of false-negatives in the region where thrombi have the greatest clinical importance. As indicated in the article, venography remains the reference procedure for the detection of deep venous thrombosis but an adequate screening procedure is desperately needed. It was suggested in our article that perhaps a combination of screening procedures might lead to more accurate forecasting of the presence of deep venous thrombosis by noninvasive means. Contrary to Dr Stockland's interpretation, our statement that "leg scanning should never be used as an exclusion test" does not necessarily imply using venography routinely. Our comments with respect to this issue are clearly stated in the text. In a clinical situation with patients undergoing total hip replacement, the time necessary for completion of the procedure coupled with the accompanying discomfort to the patient contraindicates the routine or repeated use of venography. Indeed, and I quote from our article, "venography remains the reference procedure for detection of deep venous thrombosis in the lower extremity. However, it does not lend itself to repeated examinations; therefore, an adequate screening procedure is needed." It appears to us that Dr Stockland did not carefully read the article.

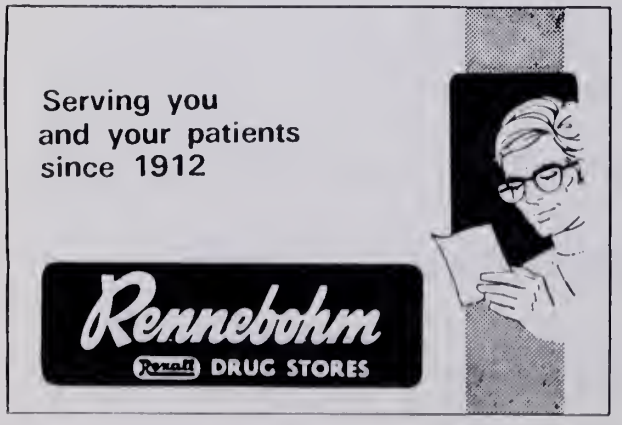
A point undetected by Dr Stockland was that some authors have inadvertently biased leg scanning evaluations by performing venography only in those cases where leg scanning or another screening technique gave positive results, suggesting the presence of deep venous thrombosis.

While we are not sure what studies Dr Stockland is alluding to that indicate an approximate 80% to 95% accuracy, the studies we reviewed used the same venographic criteria that Dr Stockland so fervently attacked in his letter.

Dr Stockland questioned the use of heparin in those patients in whom the fibrinogen I 125 scanning results were positive. This article was intended to examine the utility of leg scanning. The study was considered terminated when a positive diagnosis of thrombi was verified. Dr Stockland's concern regarding pulmonary emboli and lung scanning will be presented in the body of our next article. It had no place in the present study, which evaluated the utility of fibrinogen I 125 scanning. These studies were done and will be discussed.

If Dr Stockland wishes the readers to view this work in a true light, we suggest that superficial skepticism be put aside and replication of our results attempted with the covenant that, sometime during the hospitalization, venography should be performed whether or not the screening procedure indicates the presence of deep venous thrombosis, and that whatever data are accumulated should be submitted to the same rigid statistical analysis used in the presentation of our data.

RICHARD D SAUTTER, MD
Marshfield, Wisconsin ■



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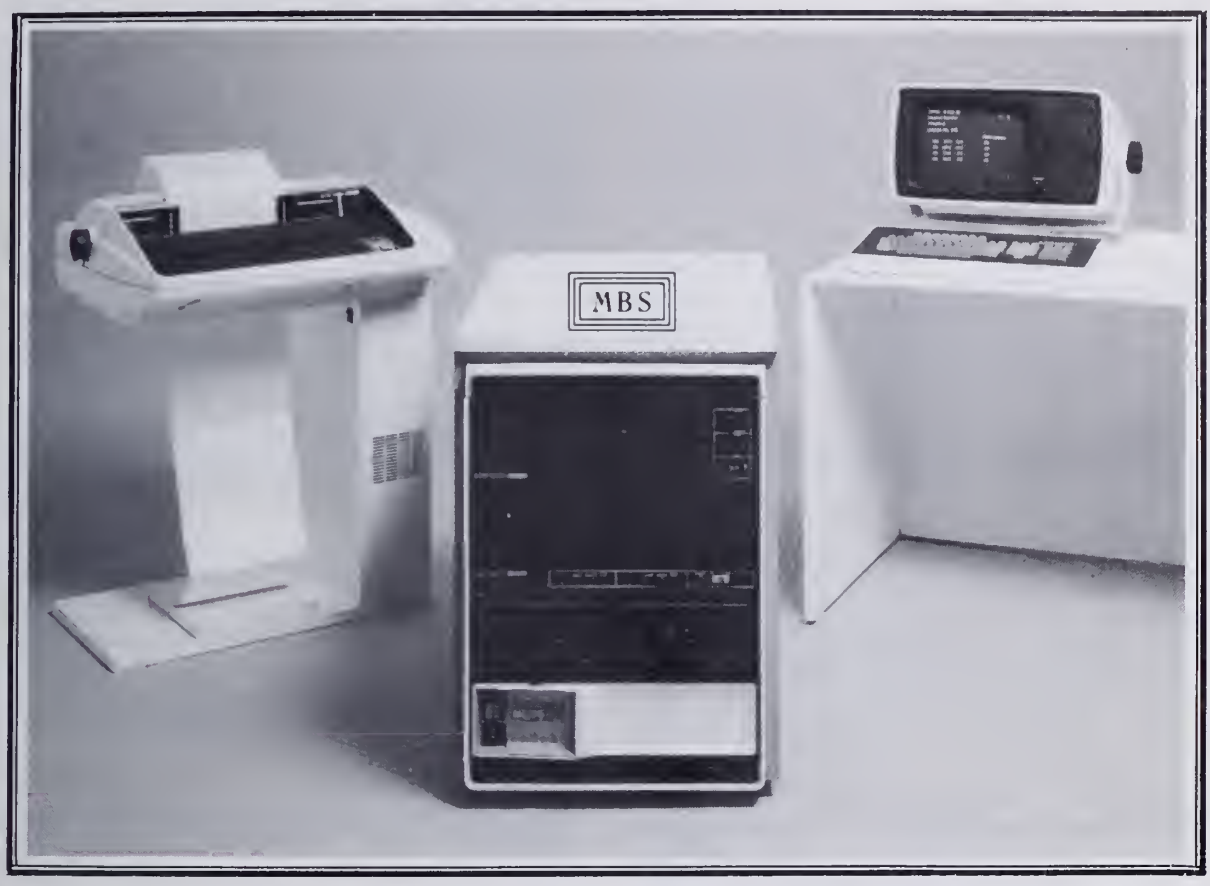

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In Perspective

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

Prophecy from the past?

Brian H Jensen, Madison, Wisconsin

Over the past few months much attention has been given, again, to the budget of the State of Wisconsin and, in particular, the appropriations granted by the Legislature for the Wisconsin Medical Assistance Program. At the same time, however, the Legislature has been considering a bill which adds a modest increase to that WMAP budget. Assembly Bill 699 seems innocent enough and little attention has been given to it as it slowly winds its way through the maze of the legislative process.

But AB 699 represents not so much a funding problem for state government as it represents the mentality still at work in the Legislature regarding "benefits" to the citizenry—in this case medical assistance. The bill adds a new benefit to the T-19 program; state assumption of all the costs connected with the funeral and burial of a T-19 recipient.

The best "healthcare" plan in Wisconsin—if AB 699 were to be enacted—would have gotten better. The bill failed to pass by April 3 when the Legislature adjourned, but not because of a rejection of its principles, but because "time" ran out as it often does late in the final legislative floor period.

While I doubt many of us have any quarrel with those who provide the services connected with funerals, some very absurd questions come to mind should AB 699 be adopted in the future. Will they be paid by a fee schedule? Will DHSS set maximum reimbursement levels? Will the Super-Rule be amended to set standards?

Believe me, I do not choose to make light of the circumstances surrounding death. However, if taxpayers ever wondered how government costs in a "medical care" program got so high, AB 699 is a good example.

My friends in the Department of Health and Social Services (yes, there are a few) tell me that the basic problem with governmental healthcare programs is that over the years benefits have added slowly and methodically with little, if any, attention paid to the long-range implications both in terms of cost and precedents. And they have been added by the Legislature session after session until Wisconsin is now faced with a new spring ritual in the Legislature called the "How-do-we-balance-the-budget-and-still-maintain-a-comprehensive-program" syndrome.

Every year at budget time the Department and the Legislature grapple with this problem, every year the checkbook is balanced, and every year someone says that the real "crisis" has been merely delayed until the next go-around. That is to say, "next year" we'll take a long, hard look because savings must be made and expenses checked.

Wisconsin has had a long tradition of progressive politics and a compassionate citizenry. It certainly is not fair to only criticize the Legislature because there is truth to its contention that legislators are responding to the demands of citizens—and special interest groups—for benefits and programs regardless of whether housed in DHSS, the DNR, or any other state agency.

However, it does not make sense, as Senator Paul Offner of LaCrosse has pointed out, to "nit-pick" the program to death while ignoring the major problems. But the Legislature and the bureaucracy have not dealt with the major problems. Physicians have advised legislators for several years that one of the most costly and abused aspects of governmental-pay programs is the use and misuse of hospital emergency rooms. With 8% of the population of the state in the medical program, that issue should be addressed.

Unfortunately, over the past few years the Physicians Alliance Commission of SMS has been so involved in the procedural aspects and "hassles" of T-19 that recommendations for major program changes have had to wait until now. That Commission has indicated its willingness to work with the Legislature to address the major problems, and the 1981 session of the Legislature will undoubtedly hear from the Commission.

Now, in the interim, the Commission needs to hear from *you*—the physician on the front lines of the battle—in order to make sense out of the program. Recommendations from organized medicine will distinguish it from nearly all other groups associated with the program, and I believe the Legislature will be inclined to listen. Periodic, piecemeal attacks are not enough; a well researched and planned approach is necessary and

Mr Jensen is Director, Physicians Alliance Division of the State Medical Society of Wisconsin. Copyright 1980 by the State Medical Society of Wisconsin.

physicians can assume a position of leadership in the process.

To be unwilling to embark on this effort means a continuing frustration with the program, its funding, and for the people—providers and recipients—who are involved. Sooner or later the systems will fail without change. I have yet to encounter a physician in Wisconsin who disagrees with the general proposition that all persons—regardless of economic status—should have adequate access to good healthcare. *How* that access is provided, and the extent of care and patient understanding of it are the real questions.

Not long ago, I read the following statement by Dr Frank Billings in the *Wisconsin Medical Journal:*

> *Much has been written of late regarding state medicine and the economic difficulties in the practice of medicine . . . we fear social medicine and the tendency since the war has been for national organizations to favor paternal medicine, but it will never succeed . . . you may talk of any health care work you please but any scheme centralized in the federal government or centralized in the state will fail.*

It appeared in the January edition of the *Journal*. . . in **1923.** ■

Bookshelf

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Every Body's Fitness Book. By Gordon W Stewart, MSc. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1980. Pp 238. Price: $5.95.

Submolecular Biology and Cancer. CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, New Jersey 07901. 1980. Pp 349.

Maternal Recognition of Pregnancy. CIBA Pharmaceutical Co. Division of CIBA-Geigy Corp, Summit, New Jersey 07901. 1980. Pp 425.

Human Genetics: Possibilities and Realities. CIBA Pharmaceutical Division of CIBA-Geigy Corp, Summit, New Jersey 07901. 1980. Pp 425.

Oxygen Free Radicals and Tissue Damage. CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, New Jersey 07901. 1980. Pp 381.

Getting What you Deserve. By Stephen A Newman and Nancy Kramer. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1980. Pp 328. Price: $8.95.

Sportsmassage. By Jack Meagher and Pat Boughton. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1980. Pp 195. Price: $6.95.

Handbook of Pediatrics. 13th Edition. By Henry K Silver; C Henry Kempe; and Henry B. Bruyn. Lange Medical Publications, Los Altos, Calif 94022. Pp 735. Price: $9.50.

Effects of the 1974-75 Recession on Health Care of the Disadvantaged. U S Department of Health, Education, and Welfare, National Center for Health Services Research, 3700 East-West Highway, Hyattsville, Md 20782. 1980. Pp 86.

Responses of Canadian Physicians to the Introduction of Universal Medical Care Insurance. U S Department of Health, Education, and Welfare, National Center for Health Services Research, 3700 East-West Highway, Hyattsville, Md 20782. 1980. Pp 21.

Effects and Costs of Day Care and Homemakers Services for the Chronically Ill: A Randomized Experiment. U S Department of Health, Education, and Welfare, National Center for Health Services Research, 3700 East-West Highway, Hyattsville, Md 20782. 1980. Pp 65.

The Right Brain. By Thomas R Blakeslee. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1980. Pp 288. Price: $10.95.

Journal of Health Politics, Policy and Law. Dept of Health Administration, PO Box 3018, Duke University, Durham, NC 27710. 1979. Pp 552.

Angel Dust. By Harvey W Feldman, Michael H Agar, George M Beschner. Lexington Books, D C Heath & Co, 125 Spring St, Lexington, Mass 02173. 1980. Pp 226. Price: $14.95.

The Brand-Name Carbo Calorie Diet. By Donald S Mart. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 367. Price: $9.95.

Handicapped Children: Strategies for Improving Services. By Garry D Brewer and James S Kakalik. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1979. Pp 612. Price: $19.95.

Current Medical Diagnosis & Treatment. By Marcus A Krupp and Milton J Chatton. Lange Medical Publications, Los Altos, Calif 94022. 1979. Pp 1130. Price: $18.00.

Healthwise Handbook. By Toni M Roberts, Kathleen McIntosh Tinker, and Donald W Kemper. Healthwise, Inc, 111 South 6th St, Boise, Idaho 83702. 1979. Pp 250. Price: $6.95.

In Defense of Ourselves. By Linda Tschirhart Sanford and Ann Fetter. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 177. Price: $5.95.

Mode of Action of Autonomic Drugs. By Dr Budh D Bhagat. Graceway Publishing Co, PO Box 159, Station "C", Flushing, NY 11367. 1979. Pp 169. Price: $17.50 (paper cover).

The Myth of Psychotherapy. By Thomas Szasz. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 248. Price: $2.95.

Review of Medical Physiology. By W F Ganong, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1979. Pp 618. Price: $14.00.

The Borderline Syndromes: By Michael Stone, MD. McGraw-Hill Book Co, 1221 Avenue of the Americas, New York, NY 10020. 1980. Pp 553. Price: $27.50. ■

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Scientific Medicine

REFER TO—Bosch A, Caldwell WL: Palliative radiotherapy in the patient with metastatic and advanced incurable cancer. *Wisconsin Med J* 79:19-21 (Apr) 1980

KEY WORDS—Radiotherapy, cancer, palliation

Palliative radiotherapy in the patient with metastatic and advanced incurable cancer

Antonio Bosch, MD and **William L Caldwell, MD**
Madison, Wisconsin

To cure sometimes
To relieve often
To comfort and support always.
—Trudeau

The primary function of radiotherapy in the treatment of malignant diseases is cure, and modern radiotherapy properly practiced can make as great a contribution as surgery in the treatment of many types of cancer, and each specialty holds a recognized place in the treatment of early cases for which cure may be expected. Furthermore, techniques using a radical dosage with curative intent almost invariably provide some palliation if treatment fails to cure. Over 60 percent of all patients with cancer receive radiation therapy at some time in the course of the disease.

In spite of the many advances in the treatment of cancer by surgery and radiotherapy, there remains a large number of patients to whom the physician can offer relief of symptoms but no hope of cure. The radiotherapist must deal with this ever-increasing number of patients who cannot be offered a cure, but for whom relief of distressing symptoms is essential.

Patients seen in a radiotherapy department consist of many patients with advanced, incurable neoplasms, and of patients with metastatic and/or recurrent disease who require palliative treatment. Palliation in such cases is not a matter of giving a sufficiently high dose to destroy every tumor cell present, but a dose that will arrest tumor growth and cause clinical regression in a short time. This will relieve distressing symptoms such as pain, obstruction, ulceration, fungating masses, hemorrhage, and others, and cause minimal damage to surrounding normal tissues and vital organs.

Certain basic principles concerning palliative radiation therapy must be applied: the relief of the main symptom should occur early during the treatment; the disturbance caused by the treatment should be minimal, serious side-effects or complications of treatment are not acceptable; the duration of the palliative treatment and hospital stay, if needed, should be short and convenience of treatment becomes major consideration; it must offer more than other palliative measures and a painful existence should not be prolonged.

The first and most important thing to realize is that prolongation of life in the presence of unrelieved pain or major distressing symptoms is not a palliation and over-treatment in the last stage of the disease is very frequently a disservice to the patient with cancer. The appropriate use of sedatives and narcotics, such as the Bromptom mixture, may provide more palliation than more aggressive, active therapy.

When palliation is considered, it is important to look at the situation from the point of view of the patient, and evaluate carefully what the palliative treatment might do for his or her mental as well as physical distress. Radiotherapy should be considered helpful only if subsequent to treatment the patient is likely to become aware that he or she has been benefited. Palliative treatment of the patient with incurable cancer must be directed only to the relief of specific distressing symptoms caused by or associated with the disease.

From the Division of Radiation Oncology, University of Wisconsin Center for Health Sciences, Madison, Wisconsin. Supported by National Cancer Institute and Wisconsin Clinical Cancer Center Grant 5 P01-CA-19278-02. Doctor Caldwell died May 21, 1979 in a tragic accident. Reprint requests to: Antonio Bosch, MD, Wisconsin Clinical Cancer Center, K4/B100, 600 Highland Ave, Madison, Wis 53792. (Phone 608/263-8500) Copyright 1980 by the State Medical Society of Wisconsin.

Pain is usually the most important and distressing symptom for the patient with advanced incurable cancer and may completely disrupt the life of an otherwise functional person. Metastatic tumor in bone is a frequent source of pain, and there are few patients who cannot be relieved by suitable irradiation. If only one or a few sites are involved, local irradiation is the best treatment available, and modest doses of 2000 to 3000 rad delivered in a limited number of fractions in a short time, one to two weeks, usually will produce rapid and complete relief in at least 80 percent of the patients.[1-3] In rare instances when metastasis is from a well-differentiated tumor such as carcinoma of the gastrointestinal tract, pancreas, cervix or endometrium, the response may be poor with modest doses, and slightly higher doses may be needed in patients whose life expectancy is good. In patients with extensive disease, the use of higher doses of irradiation to local sites is rarely preferable to neurosurgical measures designed to relieve pain, such as nerve block or cordotomy, which in skilled hands is simple and, when successful, is lasting in its effect.

"When a patient arrives at the end stages of . . . disease . . . management of the patient, rather than of the disease . . . becomes the paramount feature of care."

If multiple sites of skeletal involvement are present, the use of irradiation as a palliative measure reaches practical limitations, unless newly developed techniques of single, high dose, sequential half-body irradiation are used.[4,5] The precise indications for this approach are being assessed at present.

When pain is produced by direct involvement of peripheral nerves, as in the case of carcinoma of the rectum or cervix uteri infiltrating the sacral plexus, or of extension into the pterygoid fossa in patients with advanced tumors of the head and neck, or of involvement of cranial nerves from carcinoma of the nasopharynx, the nature of prior therapy and the general status of the patient influence the approach to palliation. Radiotherapy may be beneficial in certain relatively favorable cases, but in many patients other methods of obtaining rapid pain relief are preferable to radiotherapy. Frequently, neurological methods, such as alcohol nerve block, intrathecal phenol injection, root sections, cordotomy, or Gasserian ganglion section are required.

Obstruction of the lumen of an organ is also a frequent cause of severe distress for patients with advanced cancer. Malignant tumors infiltrating the mediastinum may cause compression of the trachea, esophagus, or large vessels, producing distressing symptoms that can usually be relieved by properly conducted irradiation techniques.[6] Bronchial obstruction with secondary pulmonary atelectasis produced by advanced carcinoma of the lung is frequently palliated by short courses of irradiation that can relieve the bronchial obstruction.

The treatment of intestinal tract obstruction varies with specific anatomical sites involved by the tumor. Intrinsic lesions obstructing the intestinal tract are rarely amenable to radiation treatment, and palliation is frequently best obtained by surgical resection, bypass, or intubation. One significant exception is carcinoma of the esophagus. In carcinoma of the esophagus, where by any treatment modality only 5 percent of the patients survive more than five years, palliative irradiation often is indicated to relieve the mechanical obstuction caused by the tumor mass protruding into the esophageal lumen. Establishment of a nearly normal esophageal passage is accomplished with simple techniques of moderate dose irradiation in over 50 percent of the patients, without side-effects or complications.

Ureteral obstruction is always a grave prognostic sign, and it is the most common cause of death in patients with advanced or recurrent carcinoma of the cervix uteri; the majority of patients with ureteral obstruction die of uremia, which is Nature's way of putting an end to their pain and suffering. Palliative pelvic irradiation may relieve the ureteral obstruction and restore the normal renal function, but will be of no benefit to the patient with progressing and uncontrollable carcinoma of the cervix uteri. Uremia is a more comfortable way for patients to end their struggle with their disease, and this course of events should not be prevented by palliative treatment.

Another major distressing symptom in patients with advanced cancer is visible blood loss. This symptom frequently occurs in patients with carcinoma of the uterine corpus and cervix, tumors of the urinary bladder and kidney, tumors of the oral cavity and pharynx, carcinoma of the lung, and metastatic ulcerated tumors in lymph nodes or soft tissues. Due to its effectiveness and the minimal associated morbidity, local irradiation of these lesions is the treatment of choice, usually using large fractions in a short period of time which results in a decrease or cessation of the bleeding.

The duration of the treatment course, when palliation is the aim, should be as short as possible, and two or three weeks of treatment should seldom be exceeded. In some cases a single treatment or a few large fractions delivered in one week is usually adequate. Convenience of treatment becomes a major consideration when palliation is the objective, and treatment facilities close to the patient's home or family should be advised.

This recommendation is made with some reservation since decisions regarding palliative treatment frequently are more difficult than for curative ones, and a team approach is equally important. As con-

venient and seemingly compassionate as it may seem to attempt palliation of patients in their home community, *unless* there are well-trained oncologists to impact on their management, patients may suffer needlessly from inappropriate treatment. When radiotherapy is used indiscriminately for palliation, treatment may have no salubrious effect.

When a patient arrives at the end stages of his or her disease, usually manifested by profound weakness, sometimes unconsciousness, marked loss of weight and failure of function of one or more vital organs, therapy directed to the cancer itself is a disservice to the patient. Management of the patient, rather than of the disease, always an important consideration, becomes the paramount feature of care.

The prolongation of life of the suffering patient with incurable cancer without relief of distressing symptoms is not palliation, but just a prolongation of the process of dying, always painful to the patient, the family, and the attending physician.

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Abstracts

The effect of lithium carbonate on lymphocyte, granulocyte, and platelet function

WILLIAM R FRIEDENBERG, MD and JAMES J MARX, Jr, PhD, Department of Hematology, Marshfield Clinic and the Marshfield Medical Foundation, Inc, Marshfield, Wis: *Cancer* 45:91-97, 1980.

Lithium affects an increase in granulocyte counts in humans and has been promoted in the treatment of granulocytopenia and as adjuvant cancer chemotherapy to reduce the incidence of bacterial infections. In this study, eight healthy volunteers were studied by means of a panel of quantitative and cellular function tests before and after a seven-day course of lithium carbonate. Granulocyte, lymphocyte, and platelet function was assessed by the test panel. This panel included T cell and B cell enumeration, lymphocyte transformation to a number of mitogens and antigens, phagocytic and bactericidal activities of peripheral leukocytes, nitroblue tetrazolium (NBT) reduction, chemotaxis, chemiluminescence, platelet aggregation studies, and Ivy bleeding time. There was a significant reduction in bactericidal capacity ($p<0.005$) and a significant reduction in lymphocyte response to PPD ($p<0.01$). Although lithium increases the granulocyte count, the reduction in bactericidal capacity of granulocytes may reduce the beneficial effect of the granulocytosis. Prospective clinical studies are indicated to assess the clinicial efficacy of the drug. ■

Local versus regional procurement and distribution of granulocytes

WILLIAM R FRIEDENBERG, MD; JAMES J MARX JR, PhD; G JOHN WEIR, MD; TARIT K BANERJEE, MD; SHENG CHANG, MD; and GARY BECKER, MD, Depts of Hematology, Endocrinology, Oncology and Pathology, Marshfield Clinic and the Marshfield Medical Foundation, Marshfield, Wis and the Badger Red Cross Blood Center, Madison, Wis: *Transfusion* 19:719-724, 1979.

Granulocyte concentrates obtained by discontinuous flow centrifugation (DFC) and continuous flow centrifugation (CFC) were studied. The DFC granulocytes were obtained from a regional center and stored for 24 hours prior to transfusion. The CFC granulocytes were obtained locally and transfused within a few hours. Even at 24 hours, DFC granulocytes had significantly reduced bactericidal capacity, chemiluminescence, nitroblue tetrazolium reduction, chemotaxis, and random mobility. Granulocyte kinetics utilizing $DF^{32}P$ and skin windows demonstrated the ability of DFC granulocytes to circulate and migrate into the tissues despite the *in vitro* abnormalities. Until effective storage techniques for granulocyte preservation became available, rapid transportation and processing from regional centers or local procurement of granulocytes is necessary to transfuse functional granulocytes. ■

REFER TO—Jacobs PA, Camitta BM, Sullivan DM: Current therapy of childhood osteosarcoma and Ewing's sarcoma. *Wisconsin Med J* 79:22-24 (Apr) 1980

KEY WORDS—Osteosarcoma, Ewing's sarcoma, childhood cancer

Current therapy of childhood osteosarcoma and Ewing's sarcoma

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Prior to 1970 only 5 to 20 percent of children with osteogenic sarcoma and Ewing's sarcoma achieved long-term, disease-free survival. However, in the past decade results of treatment of these malignancies have improved substantially. Utilizing combinations of surgery, irradiation, and adjuvant chemotherapy, 50 percent or more of children with osteosarcoma and Ewing's sarcoma may be cured. In this paper we briefly review current concepts of optimal therapy and demonstrate their application in a children's cancer center.

BACKGROUND AND METHODS

The indications for surgery, irradiation, and chemotherapy in patients with osteosarcoma and Ewing's sarcoma are summarized in Table 1.

Since osteosarcoma is radioresistant, surgical removal of the primary tumor is a necessity for curative treatment. Surgery usually entails amputation although limb-sparing procedures are now being investigated.[1] Following surgery both adriamycin and high-dose methotrexate (HDMTX) are effective against microscopic residual disease.[2,3] A combination of these agents, with or without additional drugs, has not yet been shown to be more effective than either drug alone. At the Midwest Children's Cancer Center we currently utilize HDMTX plus adriamycin for chemotherapy of osteosarcoma. HDMTX (7.5 g/M^2) is given intravenously over six hours weekly for four weeks, then every three weeks for 16 additional doses. Twenty-four hours after each HDMTX infusion, citrovorum factor (15 mg/M^2) is given every six hours for nine doses.[4] Adriamycin (60 mg/M^2) is given seven days after HDMTX (beginning with the fourth weekly dose of HDMTX). In order to prevent cardiac toxicity the cumulative dose of adriamycin is limited to 420 mg/M^2 and children are followed at periodic intervals with echocardiographic studies.[5] If metastases develop despite chemotherapy, aggressive surgery may still be curative in 25 to 30 percent of patients.[6]

Because Ewing's sarcoma of bone is locally radiocurable, initial surgery usually should be limited to biopsy of the tumor. A biopsy should provide adequate material for light and electron microscopic evaluation. The latter is often helpful in distinguishing Ewing's sarcomas from other small round cell sarcomas involving bone in children (such as neuroblastoma, rhabdomyosarcoma, and lymphomas). The biopsy should not be excessive or a pathologic fracture may occur. Biopsy should not be done through any soft tissue area that the radiotherapist may want to exclude from irradiation portals. Optimal irradiation therapy of Ewing's sarcoma includes irradiating the entire bone to 4000 rad. Thereafter radiation portals can be progressively narrowed. Areas of known initial tumor involvement should receive 5500-6500 rad.[7]

A variety of agents have activity against metastatic Ewing's sarcoma. The most active include cyclophosphamide, vincristine and adriamycin; all produce responses in 40 to 60 percent of tumors. We currently administer these agents (cyclophosphamide 300 mg/M^2; vincristine 1.5 mg/M^2; adriamycin 25 mg/M^2) every two weeks. The latter is discontinued after a cumulative dose of 450 mg/M^2; the other agents are continued for a total of 18 months. Potential adriamycin cardiac toxicity is monitored as above.

The primary sites of metastases of both osteosarcoma and Ewing's sarcoma are the lung parenchyma and bones. Patients should be followed during and after therapy with monthly chest x-rays and periodic (every six months) bone marrows and bone scans. Plain films of involved bones are also helpful in assessing healing or progression in children with Ewing's sarcoma.

RESULTS

Since establishment of our children's cancer center in 1974, eleven children with osteosarcoma and seven with Ewing's sarcoma have received treatment as outlined above. The current status of the 15 children presenting without metastases and placed initially on multimodality therapy is summarized in Table 2. Ten of 15 patients have been continuously disease-free since diagnosis; one additional patient has been disease-free for three months following resection of a femoral stump recurrence of osteosarcoma.

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Table 1—Indications for surgery, irradiation, and chemotherapy in patients with osteosarcoma and Ewing's sarcoma

	Surgery	*Irradiation*	*Chemotherapy*
Osteosarcoma	Removal of primary (en bloc or amputation); resection of lung metastases	Radioresistant	Adriamycin Methotrexate
Ewing's sarcoma	Biopsy only; may be excisional biospy for soft tissue variant[8]	Locally curative if dose, ports adequate	Cyclophosphamide Adriamycin Vincristine Actinomycin D

Two children (one with osteosarcoma and one with Ewing's sarcoma) presented with macroscopic metastases at diagnosis; they died of disseminated disease 12 to 19 months later. A third child developed pulmonary metastases of osteosarcoma four months after surgery (not followed by chemotherapy) at another institution. He is currently disease-free on chemotherapy but has required additional surgery to remove bone metastases.

DISCUSSION

Microscopic metastases are present at diagnosis in 80 percent of children with osteogenic sarcoma and Ewing's sarcoma. Thus despite definitive local eradication of the primary tumor by surgery (osteosarcoma) or irradiation (Ewing's sarcoma), most children eventually relapse at other sites. Microscopic metastases can be eliminated in half of children at risk by adjuvant chemotherapy. Thus with optimal therapy 50 to 60 percent of children with osteosarcoma and Ewing's sarcoma may achieve continuous disease-free survival with minimal risk of subsequent relapse. This figure varies depending upon the primary tumor site for both tumors.

Children with metastases at diagnosis, or developing during therapy, do poorly despite the above measures. Almost no children with metastases from Ewing's sarcoma survive. In osteosarcoma, 25 to 30 percent of children with pulmonary metastases may eventually achieve long-term, disease-free survival by means of aggressive surgery and chemotherapy.[1]

Long-term followup is necessary before disease-free survivors can be said to be cured. In osteosarcoma there is evidence that chemotherapy delays rather than eradicates metastases in some patients. Moreover an appreciable incidence of second tumors is being noted in long-term survivors of childhood malignancies.[9] These may result from therapy per se or may represent an intrinsic (genetic) increased susceptibility to neoplasia. Finally, as children survive for longer periods, long-term nonmalignant physical and emotional consequences of cancer and cancer therapy are becoming more apparent. True cure of childhood cancer must involve functional and emotional cure in addition to achievement of disease-free survival.

Table 2—Current status of children presenting without metastases

	Osteosarcoma	*Ewing's sarcoma*
Number	9	6
Continuously disease-free	5	5
Followup (months)	(31-44)	(1-58)
Recurrences		
Local (months)	1 (6)	0
Metastatic (months)	3 (2,7,10)	1 (9)
Died (months)	2 (16,38)	0
Alive with disease (months)	1 (18)	1 (39)
Alive without disease	1 (9)	0

Optimal control of childhood bone neoplasms requires expeditious evaluation, accurate diagnosis, and effective therapy. As outlined above, these require close coordination of an orthopedic surgeon, radiotherapist, and oncologist. The initial complexities of treatment are best handled at a medical center where specialists in all three disciplines are available. In addition, initial evaluation at such an institution will permit accumulation of data and experience that will eventually improve current survival rates.

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Abstracts

The Editorial Board of the *Wisconsin Medical Journal* acknowledges receipt of a group of abstracts from papers presented by MD/PhD students at the Medical College of Wisconsin's Student Research Day, May 14, 1979, in Milwaukee. Because of space limitations the Board regrets being unable to publish them; however, it would like to encourage students to continue participation in such endeavors. Therefore, a list of the titles and authors is printed below. Copies of the abstracts are available upon request to: Sally Y Long, PhD, Assistant Dean for Student Affairs, Medical College of Wisconsin, 8701 Watertown Plank Road, PO Box 26509, Milwaukee, Wisconsin 53226 (phone 414/257-8206).

* * *

- Multiple mutations affecting the rate of methemoglobin reduction in human red cells: *Karla J Matteson; J Libnoch, MD;* and *F Taketa, PhD,* Department of Biochemistry, MCW.
- Invasive blood pressure measurements during valsalvia maneuver in patients with coronary heart disease: *C J Porth; J A Reinke; D F Stowe, PhD; V S Bamrah, MD; F E Tristani, MD; J A Leibsohn;* and *J J Smith, MD, PhD,* VA Medical Center and Department of Physiology, MCW.
- Malachite green as a stain for electron microscopy (EM) of bacteria: *W M Dunne Jr; V Kushnaryov, MD;* and *F L A Buckmire, PhD,* Department of Microbiology, MCW.
- Resetting of carotid baroreceptors in chronic localized hypotension: *F O Igler; J H Donegan, MD;* and *J P Kampine, MD, PhD,* Department of Physiology, MCW.
- Determination of blood vessel catecholamine concentration during development of hypertension in the spontaneously hypertensive rat: *P Fellenbaum; S J Contney; W J Stekiel, PhD,* Department of Physiology, MCW.
- A reliable method of surgically inducing chronic sinoatrial node block: *W A Getzel; J M Orlowski; M J Esser; M J Kileen; M A Grajewski; R A Staudacher; S J Teeter; J P Kampine, MD, PhD;* and *D C Jeutter,* Department of Physiology, MCW.
- Biochemical comparison of rat and human immunoglobulin E: *Larry McKean* and *Jeffrey Winkelhake, PhD,* Department of Microbiology, MCW.
- Effect of thioridazine on serum levels of anticonvulsant drugs, *Thomas Snyder; J V Murphy, MD;* and *Bernard D'Souza, MD,* Department of Neurology, Milwaukee Children's Hospital.
- Interferon inhibits the differentiation of 3T3-L1 cells, *Susan Keay* and *S E Grossberg, MD,* Department of Microbiology, MCW.
- Attempts to detect enterovirus antigens in cerebrospinal fluid by countercurrent immunoelectrophoresis, *C L Hutchinson* and *M W Rytel, MD,* Department of Medicine, MCW.
- A sensitive bioassay for human plasma corticotropin releasing factor, *D C Newell; T L Garthwaite;* and *T C Hagen, MD,* Department of Medicine, MCW.
- A study of membrane-bound ganglioside-interferon interaction; using electron spin resonance spectroscopy, *Howard Elconin* and *Helmut Ankel, PhD,* Department of Biochemistry, MCW.
- Interaction of cardiac and arterial baroreceptors, *Michelle Hayes* and *John Kampine, MD, PhD,* Department of Physiology and Anesthesiology, MCW.
- Effect of liver perfusion blow rate on liver viability and somatomedin bioassay, *M R Bohnsack; K J Gaspard, PhD;* and *H M Klitgaard, PhD,* Department of Physiology, MCW.
- Effect of veratridine on the uptake of lithium into rat brain, *B S Holzman* and *R H Belmaker, MD,* Department of Psychiatry, MCW.
- Biosynthesis of acetylated and non-acetylated cat B^B globin, *J C Kasten-Jolly* and *Fumito Taketa, PhD,* Department of Biochemistry, MCW. ■

REFER TO—Starling JR: Peritoneovenous shunting in the management of malignant and cirrhotic ascites. *Wisconsin Med J* 79:25-29 (Apr) 1980

KEY WORDS—Peritoneovenous shunting, ascites, LeVeen shunt, cirrhosis

Peritoneovenous shunting in the management of malignant and cirrhotic ascites

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• *The peritoneovenous shunt (LeVeen shunt) is an effective way to manage selected patients with medically refractory ascites secondary to a variety of causes. Over the past 18 months, 10 of 13 patients with cirrhotic or malignant ascites were treated successfully with a LeVeen shunt. Severe complications can occur; therefore, careful patient selection is important.*

Massive ascites can affect patient mobility, respiration, and nutrition. Most patients with cirrhotic ascites can be successfully managed with fluid—salt restriction, and diuretics. When the ascites becomes refractory to medical management, or when aggressive medical therapy compromises the extracellular fluid space leading to renal failure, surgical management in selective patients is warranted. Prior to 1975 the portacaval shunt was the only surgical procedure which showed consistent success in relieving ascites. The portacaval shunt, however, frequently resulted in severe fluid and electrolyte disturbances and an unacceptably high postoperative morbidity and mortality.

The effectiveness of the peritoneovenous shunt (LeVeen shunt*) in relieving intractable cirrhotic ascites has been gaining wide acceptance at many institutions. Most patients treated with a LeVeen shunt have alcoholic cirrhosis as the underlying disease process. The shunt also has been placed in patients with ascites secondary to post necrotic cirrhosis, Budd Chiari syndrome, chyle, renal failure, and amyloidosis.[1] Successful application of the LeVeen shunt to treat malignant ascites has been reported in only a few patients.[1,2,3,4]

The LeVeen shunt consists of a siliconized tube with a pressure-sensitive, one-way valve which allows flow of ascitic fluid as long as the intraperitoneal pressure exceeds the central venous pressure by 3-5 cm of water. The afferent limb of the shunt is placed in the abdominal cavity and the valve extraperitoneally. The efferent limb is tunneled subcutaneously across the chest and threaded into the superior vena cava, either via the external or internal jugular vein.[1]

Over the past 18 months, 13 patients with intractable cirrhotic ascites or malignant ascites were treated with a LeVeen shunt. Ten patients had alcoholic cirrhosis, and three patients had cancer as the underlying disease process. Three of these patients are presented in detail below.

CASE REPORTS

Case 1. A 27-year-old male was admitted complaining of severe shortness of breath, a recent increase in his abdominal girth, intermittent abdominal pain, and early satiety. The patient was hospitalized six years prior to this admission for right inguinal pain and was found subsequently to have an embryonal cell carcinoma of the right testicle. One year later retroperitoneal metastasis developed. Since then, he has been treated with a variety of chemotherapeutic drugs, as well as irradiation, with limited success.

Physical examination revealed a well-developed but chronically ill-appearing male weighing 37 kg with tense abdominal distension measuring 38 cm in diameter. There were no palpable abdominal masses. The shaft of the patient's penis, scrotum, and ankles revealed four plus pitting edema. His right arm blood pressure was 110/70 mmHg supine and 100/70 mmHg standing; radial pulse was 80 supine and 92 standing with labored respirations at 16 to 22 per minute.

On this admission the patient's hematocrit reading was 38.3% and a hemoglobin level was 13.39 g/dl; the white blood cell count (WBC) was 4100/mm^3, and platelets 110,500/mm^3. His coagulation parameters were normal. Liver function studies were normal except for a slight elevation in γ—GT. The chest x-ray film demonstrated marked elevation of the hemidia-

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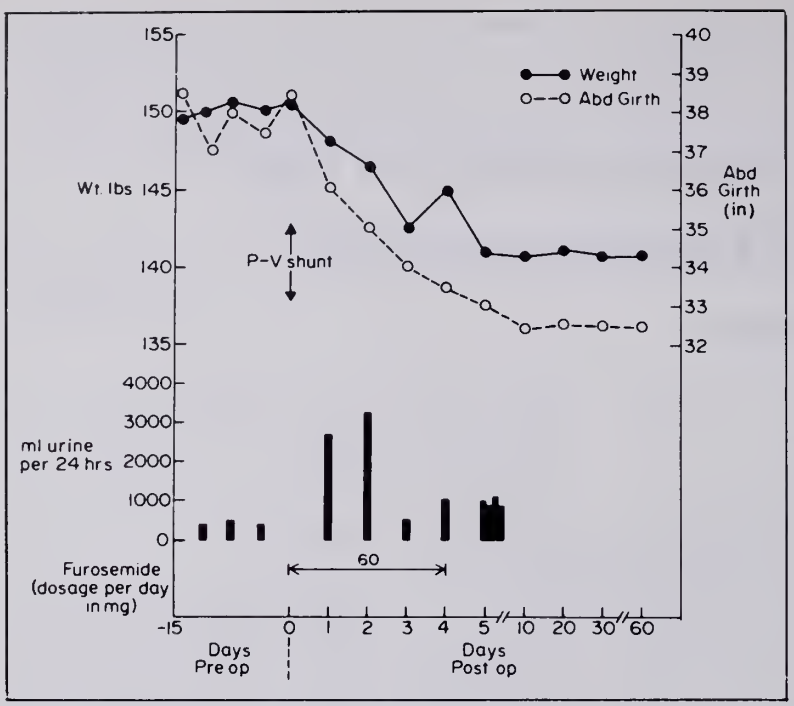

Figure 1—*Weight, abdominal girth, and initial urine output of patient in response to peritoneovenous shunt in Case 1.*

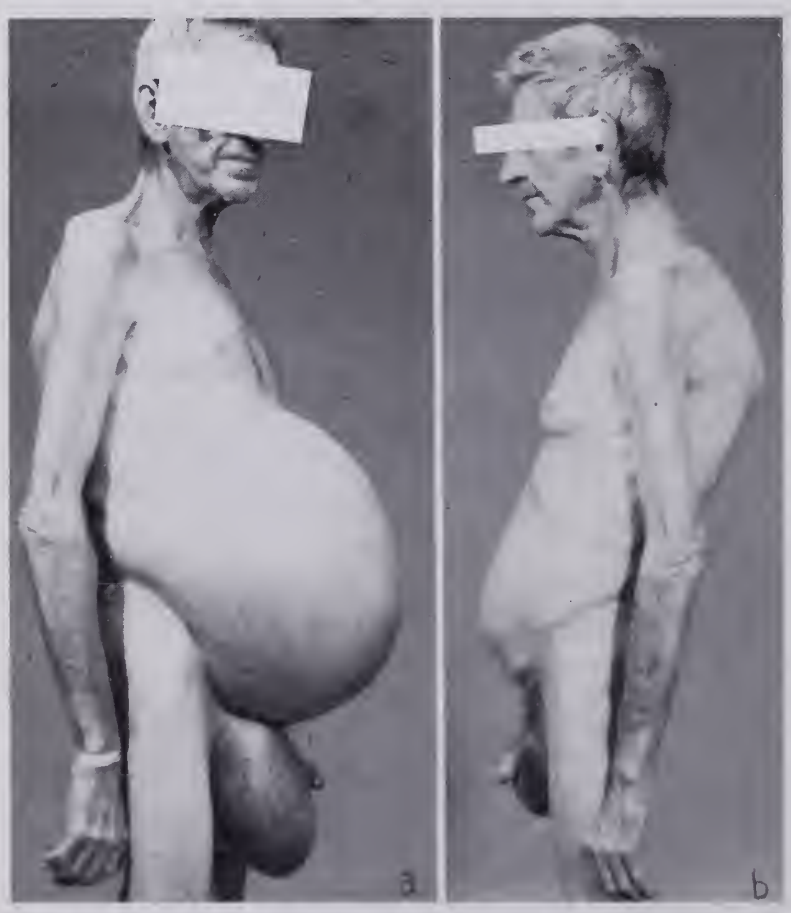

Figure 2—*Patient in Case 2 immediately prior to placement of the peritoneovenous shunt and ten days postoperatively.*

phragms with a left pleural effusion. Abdominal x-ray studies and ultrasound examinations were remarkable for severe ascites.

During five weeks of hospitalization, the patient underwent multiple paracenteses with the removal of approximately 15 liters of ascitic fluid. Cytologic examination of the straw-colored, translucent fluid was positive for malignancy. The fluid contained 89 WBC/mm^3, 445 RBC/mm^3, and a protein of 1.6 g/dl. There was always rapid accumulation of the ascites with a worsening of the patient's dyspnea and no change in his weight or abdominal girth. Diuresis could not be achieved with medication. In order to rule out a Budd-Chiari-type syndrome or inferior vena cava obstruction secondary to tumor, a selective celiac axis arteriogram was performed. Visceral arteriograms and venograms were normal, showing no evidence for portal hypertension or hepatic vein obstruction.

The patient received a LeVeen shunt under local anesthesia. Digitalis and antibiotics were administered prior to the operation. Postoperatively, furosemide was administered intravenously for four days. The patient's fibrinogen, fibrin split products, and platelets were monitored closely; they did not show any evidence for a subclinical coagulopathy. The postoperative course was uneventful and the patient was discharged from the hospital on the eighth postoperative day. His abdominal distension, dyspnea, left pleural effusion, scrotal, penile, and ankle edema were almost completely resolved. Three months postoperatively the patient was asymptomatic. The abdominal girth and weight data are seen in Figure 1.

Case 2. A 57-year-old male was admitted complaining of abdominal swelling and a large right scrotum. He stated that the abdominal and scrotal swelling began ten months prior to this admission and had become so severe that he has had difficulty ambulating (Fig 2a,b). His history indicated heavy

alcohol consumption for 24 years.

The patient was initially managed with paracentesis every other week for ten months in which 4 to 6 liters of the ascitic fluid were removed. In addition, he was treated with spironolactone and furosemide. Despite vigorous therapy, the abdominal and scrotal swelling persisted.

On admission the patient was a pleasant, slightly cachetic male in no acute distress. He weighed 76 kg (167 lb) and his vital signs were stable. Pertinent physical findings were dry, flaky skin, spider angiomata over the face, neck, and shoulders, one plus pretibial edema, marked tense ascites with shifting dullness, and a 22 cm diameter right scrotal communicating hydrocele without bowel sounds.

The patient had a hematocrit reading of 44%; hemoglobin level of 14 g/dl; white blood cell count, 4500/mm^3; and platelets, 186,000/mm^3. Plasma albumin was 3.2 g/dl. Liver function, coagulation, and serum electrolytes were within normal limits. Supine aldosterone concentration was elevated to 161 mg/dl. Upright and flat plate abdominal x-ray films showed severe ascites. The liver and spleen were both enlarged on ^{99m}Tc-sulfur colloid scan.

Paracentesis yielded clear, yellow fluid with 150 WBC/mm^3 (25% polymorphonuclear leukocytes, 75% lymphocytes), 20 RBC/mm^3. Total protein of the ascitic fluid was 2.5 g/dl; lactic dehydrogenase, 64 mμ/ml; amylase, 28 μ/dl; and glucose, 128 mg/dl. The fluid was sterile and cytologic tests were negative for malignancy.

The patient was treated for four weeks in the hospital with salt restriction, bed rest, and diuretics. He was refractory to all medical trials and his weight, abdominal girth, and tense ascites showed no change.

A LeVeen shunt was placed under local anesthesia via the external jugular vein without complication. The patient was discharged from the hospital after 11 days with resolution of most of the ascites and the communicating hydrocele. Two weeks postoperatively the supine aldosterone concentration was 9.5 mg/dl. The patient continued to show an excellent result one year later (Fig 3).

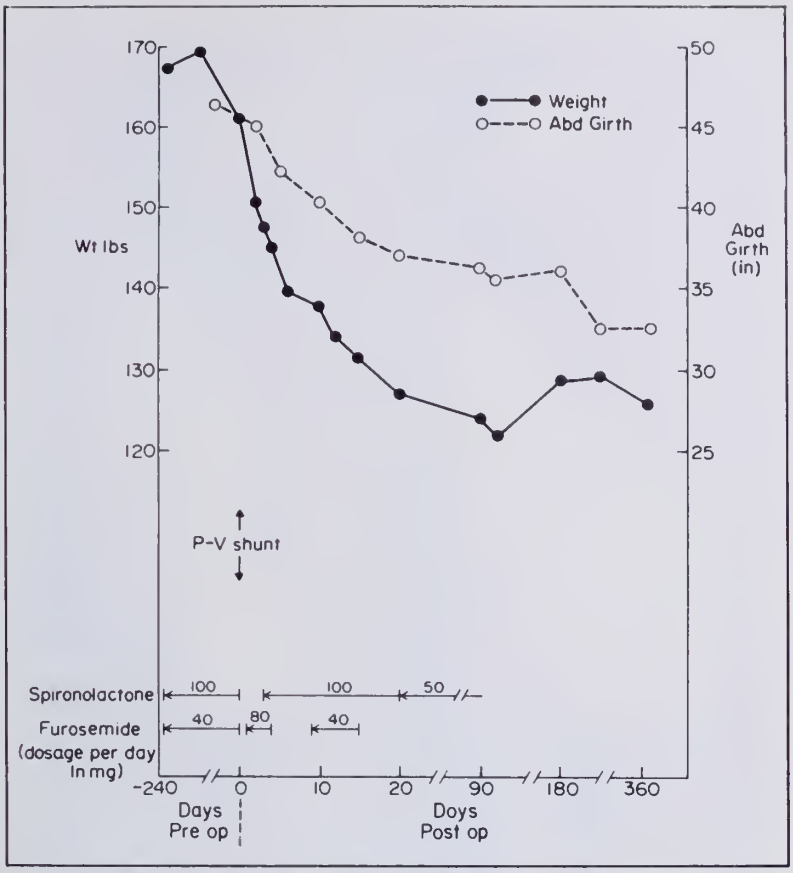

Figure 3 — *Weight and abdominal girth of patient in response to peritoneovenous shunt in Case 2.*

Case 3. A 60-year-old male was admitted with progressively severe abdominal swelling, shortness of breath, regurgitation of food, and pedal edema.

On admission he was a cachectic, chronically ill-appearing male in moderate respiratory distress (25-30 respirations/min) in the supine position (Fig 4a,b). The rest of his vital signs were normal. Medical history revealed that he was a chronic alcoholic. His skin showed multiple spider angiomata. The upper thorax revealed muscle wasting, intercostal retractions, and clavicular-periclavicular space wasting. His abdomen was tense with ascitic fluid and measured 51 inches in girth. A fluid wave could be percussed. There was three plus pitting edema to the mid-thigh. His white blood cell count was 4000/mm^3; hematocrit reading, 31%; hemoglobin level, 10 g/dl; and normal platelets. His total protein was 6.5 g/dl, albumin, 2.6; serum sodium was 127mEq/1; potassium, 4.1mEq/1; creatinine, 1.9 mg/dl; blood urea nitrogen, 8 mg/dl; serum glutamic oxaloacetic transaminase, 23 mμ/ml; lactic dehydrogenase, 126 mμ/ml; and total bilirubin, 1.5 mg/dl. Plasma fibrinogen was 525 mg/dl and fibrin split products $>10<40$ mg/dl.

Analysis of the patient's ascitic fluid revealed 110 WBC/mm^3 (36% polymorphonuclear leukocytes, 64% lymphocytes). The fluid was sterile and had a protein concentration of 2.0 g/dl.

The patient was placed on bed rest and started on spironolactone, intermittent furosemide, fluid-salt restriction, and a moderate protein diet. His urine output averaged 300 ml per day with only a slight

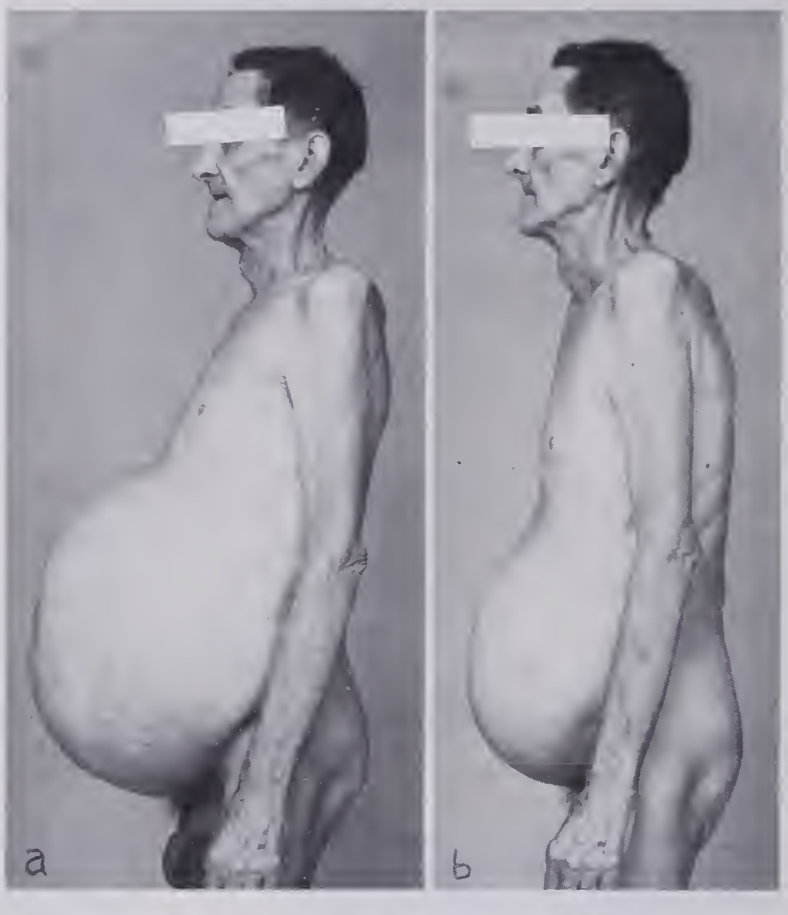

Figure 4 — *Patient in Case 3 immediately prior to placement of the peritoneovenous shunt and 11 days postoperatively.*

decrease in weight. After four weeks, the ascites remained tense and refractory to medical management. The patient's dyspnea became worse.

A LeVeen shunt was placed under general anesthesia via the internal jugular vein. Postoperatively the patient had a three-day febrile course, as well as a decrease of the plasma fibrinogen to 200 mg/dl, an increase in fibrin split products to > 40 mg/dl, a decrease in the platelet count to 182,000/mm^3, and a fall in hematocrit. There was no clinical evidence for a significant coagulopathy. Urine outputs at 24, 48, and 60 hours were 4095, 6260, and 6545 ml, respectively. The patient's postoperative course was excellent, and he was discharged asymptomatic from the hospital in 12 days. Weight and abdominal girth data are seen in Figure 5.

DISCUSSION. In certain patients the LeVeen shunt is an effective way to decrease ascites and relieve symptoms related to mobility, dyspnea, and problems of early satiety and regurgitation. The LeVeen shunt also has been reported to benefit patients with intractable ascites and coexistent renal failure secondary to alcoholic hepatitis, nephrotic syndrome, hepatorenal syndrome, and pancreatic disease.[1,5,6,7] However, there are not enough data to support the widespread application of the LeVeen shunt other than in the stable, diuretic-resistant, alcoholic, cirrhotic patient with a high-grade, intrahepatic, postsinusoidal block. Most clinicians experienced with the use of the LeVeen shunt report the following absolute contraindications for its placement: hepatic encephalopathy, deteriorating liver function, hyperbilirubinemia, prothrombin time greater than four seconds over control, active liver disease, labile cardiac status, potential for a consumption coagulopathy, infection, and a history of bleeding esophageal varices without prior porta-systemic shunt.[8]

Two case reports in this paper illustrate the efficacy of the LeVeen shunt in the stable, alcoholic, cirrhotic patient with refractory ascites. In addition, the patient in Case 1 who had ascites secondary to malignancy illustrated that excellent palliation can be achieved with relative safety. Straus, et al[4] recently reported that successful palliation of debilitating malignant ascites was achieved in 27 of 37 patients in which the LeVeen shunt was used.

Two other patients treated by this author for malignant ascites have had excellent palliation. One patient with abdominal carcinomatosis secondary to leiomyosarcoma died one month after shunt insertion. At autopsy, no ascites was present in the abdominal cavity and the shunt was patent. Two of the patients in this series who died in the immediate postoperative period had hepatorenal syndrome with encephalopathy and progressively deteriorating liver and renal function. One of these patients who had a history of bleeding esophageal varices had a massive esophageal hemorrhage with a diffuse intravascular coagulopathy postoperatively. In retrospect, these two patients should not have undergone surgery. The other death in this series occurred after successful surgery 60 days postoperatively from an infected shunt which resulted in irreversible septic shock.

SUMMARY. The peritoneovenous shunt is effective in relieving intractable malignant or cirrhotic ascites in certain patients. In this series 10 of 13 patients had an excellent or good result. Potentially serious complications can occur.[1,8,9] Therefore, recommendations for use of this shunt must be evaluated in the context of the patient's symptons and disap-

pointing prognosis if surgical intervention is not attempted.

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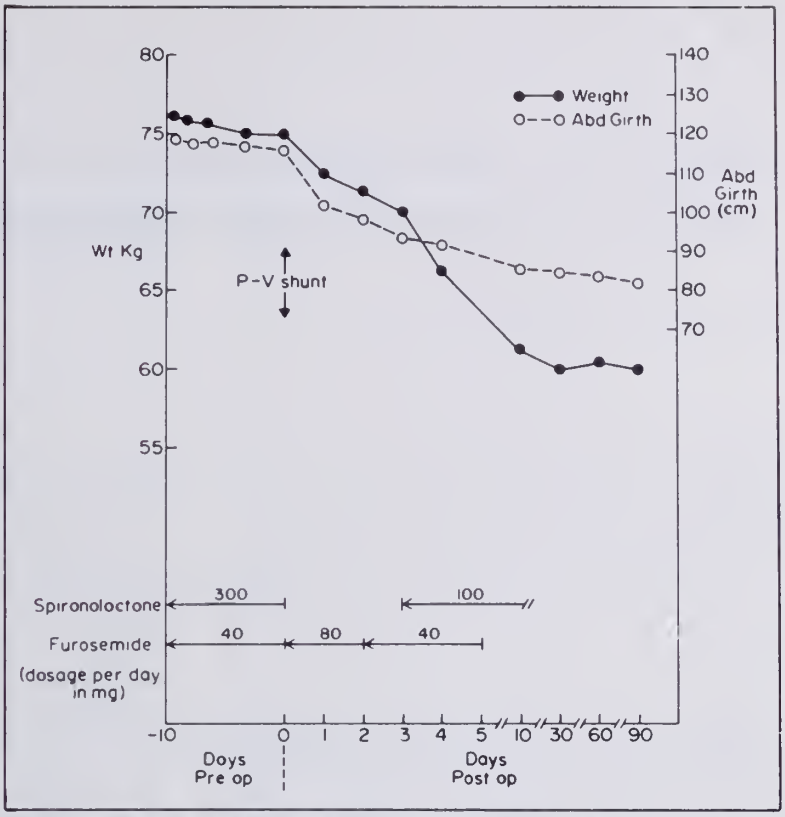

Figure 5 — *Weight and abdominal girth of patient in response to peritoneovenous shunt in Case 3.*

Abstracts

Prognostic signs in chronic myelocytic leukemia

ROBERT F SCHILLING, MD; JOHN J CROWLEY, PhD (Departments of Medicine, Statistics, and Human Oncology, University of Wisconsin, Madison, Wis): *Am J Hematology* 7:1-10, 1979.

A retrospective search for prognostic factors was made of the medical records of 127 patients with chronic myelocytic leukemia (CML) seen at the University of Wisconsin Hospitals between 1952-1976. The median age was 57 years and the median survival 53 months. Although the age of onset is similar, women appear to live longer than men. This favorable survival was not due to other recognized favorable features like normal platelet counts, presence of Philadelphia chromosome, normal chest x-ray films, or busulfan therapy, but fewer women had a low hematocrit reading and low white blood cell count. Patients with the abnormal Philadelphia chromosome were considerably younger and lived longer. Those without the chromosome had a significantly lower leukocyte count but not a lowered platelet count. Thrombocytopenic patients had significantly shorter life spans. A high myeloid/erythroid ratio in the marrow was probably a favorable sign. Differences in survival were not found when the patient population was studied for age, blasts and promyelocytes, basophiles, leukocyte alkaline phosphatase, hematocrit, serum uric acid, serum lactic dehydrogenase, weight loss, weakness, hepatomegaly, splenomegaly, or tumor mass. Patients with both a low hematocrit and white blood count had a shorter life span, while those with a low uric acid and high cholesterol level lived longer than those who did not. Three patients with myelofibrosis at the time of diagnosis had a very short survival. ■

REFER TO—Frens DB: Superior oblique myokymia; a treatable cause of monocular diplopia. *Wisconsin Med J* 79:30-31 (Apr) 1980

KEY WORDS—Monocular diplopia, superior oblique myokymia, carbamazepine (Tegretol®) therapy

Superior oblique myokymia: a treatable cause of monocular diplopia

David B Frens, MD, Marshfield, Wisconsin

• *Superior oblique myokymia is a disorder of unknown etiology presenting clinically as a complaint of monocular torsional diplopia and/or oscillopsia. The condition can be symptomatically bothersome but appears to be prognostically benign. Successful response to treatment with carbamazepine (Tegretol®) appears to be an effective therapy in the majority of individuals presenting with this clinical entity.*

The complaint of diplopia or oscillopsia causes immediate concern as it is often associated with significant neurologic disease. In contrast, the report of monocular diplopia or monocular tilting or jumping of the visual object is initially often received with a fair degree of skepticism regarding the organicity of the complaint.

In 1906 Alexander Duane[1] reported a healthy 24-year-old female with a two-year history of brief but recurrent episodes during which objects viewed with her left eye appeared to dance up and down. The patient had none of the signs then usually associated with acquired forms of monocular nystagmus such as unilateral amblyopia, unilateral opacity of the ocular media, or multiple sclerosis. On examination he noted rapid rotary and vertical nystagmus of her left eye and reported the entity as "unilateral rotary nystagmus." This condition subsequently has been the subject of at least three reports and has been termed superior oblique myokymia or alternately intermittent uniocular microtremor.[2,3,4] The purpose of this report is to describe a case of superior oblique myokymia and its response to treatment.

CASE REPORT. A 19-year-old female in the fall of 1978 noted the onset of intermittent twitching of her right eye. The intermittent twitching was initially associated with blurred vision but subsequently with double vision. The ocular twitching and associated visual impairment occurred episodically, especially while reading. It would often disappear when her attention was distracted or when she was not engaged in visually demanding activity. The episodes increased both in frequency and duration but then stabilized being present intermittently on most days. She was confident that only her right eye was involved. The remainder of her ophthalmologic, neurologic, and general medical review of signs and symptoms was negative. The general medical and neurologic examinations were normal. Ophthalmologic examination revealed normal visual acuity and visual fields. The funduscopic examination was normal. The extraocular muscles showed full excursion in all visual fields and optical kinetic nystagmus (OKN) testing was normal. Slit lamp examination showed 10 to 15 second bursts of low amplitude high frequency intorsional nystagmus limited to the right eye. This same intermittent movement abnormality could be seen with the ophthalmoscope focused on a conjunctival vessel. Laboratory studies including a complete blood cell count, sedimentation rate, routine biochemical screens, syphilis test, skull x-rays, and electroencephalographic studies with special eye montages attempting to record the eye movements, and a computerized tomographic (CT) scan with orbital views were all normal. She was started on carbamazepine (Tegretol®) in a slowly increasing dosage to a total of 600 mg per day and noticed a virtually complete disappearance of her symptoms.

DISCUSSION. There are now approximately 13 cases of this distinctive neuro-ophthalmologic condition known as superior oblique myokymia. The symptoms consist of a series of complaints including visual and/or ocular quivering, twitching, flickering, and jumping. On occasion the patient will report initially experiencing an intermittent tilting of the image in one eye followed some days to months later by a sensation of fluttering of the eye or oscillation of the displaced image. The symptoms tend to be worse with reading, driving, visually demanding work, or when gazing in the specific direction which involves the action of the affected superior oblique muscle.

Paper presented in part at the 22nd meeting of the Wisconsin Neurological Society, Green Lake, Wisconsin, June 1-2, 1979. Doctor Frens is a pediatric neurologist, Department of Neurology, Marshfield Clinic, Marshfield, Wisconsin. Reprint requests to: David B Frens, MD, 1000 North Oak Ave, Marshfield, Wis 54449 (Phone 715/387-5868). Copyright 1980 by the State Medical Society of Wisconsin.

The patient usually knows the precise ocular maneuver which will produce an attack of ocular symptoms. The symptoms usually last a matter of seconds but in some cases have increased in duration until they are persistently present. The symptoms may remit and relapse.

The signs associated with superior oblique myokymia include rapid monocular intorsional oscillations of high frequency and low amplitude. The movements may be evident on confrontation or their discovery may require the use of an ophthalmoscope or a slit lamp. The movements may be accentuated by looking in the direction of action of the involved superior oblique muscle. The remainder of the ophthalmologic and neurologic examination is invariably normal except for an occasional hyperphoria indicating overaction of the involved superior oblique muscle.

The age of onset in reported cases has been from the teens into the 60s. The duration of symptomatology has been from several days to many years.

Treatment has been both surgical and medical. A case reported by Hoyt[2] and one reported by Susac and Smith[3] responded to surgical therapy consisting of tenotomy of the involved superior oblique muscle with recession of the inferior oblique muscle.

Medical management has consisted of the use of a number of medications including diazepam, phenobarbital, and phenytoin. There has been no reported response to these medications. Several patients have received edriphonium chloride (Tensilon®) with no improvement in symptomatology.

In 1973 Susac and Smith[3] reported the favorable response of superior oblique myokymia to treatment with carbamazepine (Tegretol®). In those patients who responded the response usually occurred after several days of therapy and at a relatively low dose. At present this would appear to be the preferred method of therapy for this condition. Surgical intervention probably should be limited to those cases which do not respond to medical management.

The pathophysiology of this condition is not understood. Electromyographic studies of the ocular muscles of one of Hoyt's patients showed rapid phasic firing of abnormal units in the involved superior oblique muscle without corresponding inhibition in the inferior oblique muscle. They speculated that pathophysiologic changes in the membrane threshold of the neurons in the trochlear nucleus was a possible explanation. The work on the pathophysiology of this condition has not progressed beyond this point.

Superior oblique myokymia appears to be a distinctive neuro-ophthalmologic condition. The purpose of this report is to present a patient troubled by the symptoms of this entity and to review the literature which emphasizes that superior oblique myokymia is a symptomatically bothersome but prognostically benign condition which in most cases appears to respond very favorably to medical management.

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Abstracts

Presented at the Spring Meeting of the Wisconsin Neurological Society
June 1-2, 1979, Green Lake, Wisconsin
Francis M Forster, MD, Madison, Program Chairman

Multicore core disease

A R Sulaiman, MBBS, FRCP (C); James W Albers, MD, PhD; and Kenneth Siegesmund, PhD,
Milwaukee, Wisconsin

Lesions similar to central core disease but much smaller and numerous were first described by Engel, Gomez and Groover (1971) in two cases under the term "multicore disease." Since their description, nine cases of multicore disease have been reported. A sporadic case of multicore disease which showed slowly progressive clinical deterioration and muscle biopsy showing previously unreported histochemical findings was presented.

The patient was a 17-year-old woman, a product of uneventful term pregnancy and delivery. Her motor milestones were delayed and weakness of legs was noted at age 3½ years. She began to develop scoliosis at age 8 years which required spinal fusion at age 12 years. Examination showed above normal intelligence, diffuse muscle wasting and weakness, greater proximally, including weakness of neck muscles, and face.

Electromyography showed diffuse severe myopathy.

Muscle biopsies performed at age 12 years and recently showed evidence of multicore disease, involving practically every fiber with many fibers showing confluence of multicore lesions to give appearance of central core disease. Histochemically there is a significant preponderance of Type I fibers. The few Type II fibers that were present were all of Type II-B. Both fiber types were affected. Core lesion was also noted in the intrafusal fiber. Electronmicroscopy showed typical lesions of central core and multicore. ■

Penicillamine-induced myasthenia gravis

Richard J Hodach, MD; James W Albers, MD; and **William L Treacy, MD,** Milwaukee, Wisconsin

Penicillamine is being used with increased frequency in treating rheumatoid arthritis. Common adverse reactions are those of renal and hematopoietic toxicity, although it has been implicated causally with several autoimmune disorders including lupus erythematosus, Goodpasture's syndrome, polymyositis, pemphigus vulgaris, and myasthenia gravis. The literature contains 41 cases of presumed penicillamine-induced myasthenia gravis since 1974. Thirty-nine of the patients had rheumatoid arthritis and two had Wilson's disease. Twenty-seven cases had electrophysiologic studies and in only 5 of 27 was the data supportive of a diagnosis of myasthenia gravis.

The case reported was a 48-year-old woman with moderately severe rheumatoid arthritis who developed fatigability and proximal muscle weakness plus severe masseter weakness four months after beginning penicillamine therapy. Clinical electrophysiologic studies indicated a severe defect of neuromuscular transmission of the type seen in myasthenia gravis: Repetitive stimulation of the ulnar and musculocutaneous nerves at low rates (3 hz) produced a 35% decrement which repaired almost completely immediately after exercise and became more pronounced two to four minutes after exercise; single fiber electromyography (EMG) demonstrated intermittent blocking of individual muscle fiber potentials with a marked increase in jitter.

The pathophysiologic relationship between penicillamine and the development of myasthenia gravis is uncertain. This uncertainty is apparent by the lack of supportive EMG data in most of the previously reported cases but also by the variability of the clinical spectrum. In some individuals withdrawal of penicillamine is associated with rapid recovery; in others, a short-term course of anticholinesterase therapy is required before recovery is obtained; in still others, anticholinesterase therapy has been ineffective necessitating thymectomy or thymic irradiation.

Furthermore, several cases have been associated with an initial elevation of acetylcholine-receptor antibody titres that decrease with withdrawal of penicillamine and clinical improvement. This raises further questions as to whether penicillamine is unmasking a latent neuromuscular defect or is immunologically inducing a disorder similar to classical myasthenia gravis. Alternatively there may be only a coincidental relationship between myasthenia gravis and the underlying disease in these patients.

The patient reported remained symptomatic four months after discontinuing penicillamine, demonstrating neither improvement in muscle weakness nor reduction of Mestinon requirements. ■

Deterioration of penicillamine-induced myasthenia gravis with pancuronium

Robert W Graebner, MD; James W Albers, MD, PhD; and **Robert D Gilbert, MD,** Madison, Wisconsin

This was a case report of a patient with penicillamine-induced myasthenia gravis. Six months after penicillamine was discontinued because of mild ocular symptoms, the patient was nearly asymptomatic. A standard dose of pancuronium administered for a routine cholecystectomy produced rapid and severe paralysis which required reversal with edrophonium and neostigmine at the conclusion of surgery. Neurophysiological studies, including single fiber electromyography, confirmed the presence of neuromuscular junction dysfunction typical of myasthenia gravis. This case demonstrated the importance of recognition and close followup of neuromuscular symptoms in patients receiving penicillamine therapy. ■

The role of CT scanning in epilepsy

Francis M Forster, MD and **Charles M Strother, MD,** Madison, Wisconsin

This paper presented the results of computerized tomographic (CT) scanning in 65 consecutive patients with epilepsy studied at the William S Middleton Memorial VA Hospital in Madison. They were predominantly male, and had an average age of 41 years, with average age of onset of

seizures at 33 years. The seizures were presumed to be post-traumatic in 29 patients.

The CT scans revealed abnormalities in 43% of the patients and included four unsuspected brain tumors, three of whom were presumed to have post-traumatic seizures. The abnormalities were of value in understanding the patients problems also, for example the noncompliance and other deviations occurring in the patients with frontal lobe destruction as shown by CT. Normal scans also are valuable for they offer reassurance that no large destructive lesion is present in the post-traumatic or toxic-seizure patient.

When compared with other laboratory methods of study, CT scan was found to be superior to skull x-ray films and to nuclear scanning. While the electroencephalogram shows a much higher percentage of abnormality (66.1%), it lacks the preciseness of structural definition and pathologic interpretation. CT scanning has a very special role in the management of the epileptic patient whose seizures are symptomatic or suspected of being so. ■

Spindle coma

Phiroze L Hansotia, MD; Paul G Gottschalk, MD; Phillip M Green, MD, and **Duane Zais, R EEG T,** Marshfield, Wisconsin

Three hundred eighty-five comatose patients were studied clinically and electrographically over six years. Twenty-two patients (5.7%) had spindle coma electroencephalograms (EEGs). The etiology included head injury, intracranial hemorrhage, and anoxia. A variety of clinical features was associated with characteristic spindle coma EEGs. The presence of sleep activity, including spindles, did not influence outcome. Polymorphic, spontaneously fluctuant and consistently reactive background activity consistently associated with good prognosis and vice versa. At autopsy lesions of the centrum medianum, thalamic nuclei and ponto-mesencephalic brainstem were most frequent. Spindle coma EEGs, contrary to current belief, seemed to have little prognostic value. ■

Diagnostic studies in communicating hydrocephalus

Bhupendra Khatri, MBBS; Winslow J Borkowski, MD; and **William J Willems, MD,** Milwaukee, Wisconsin

Seventeen patients who had the clinical triad characteristic of normal pressure hydrocephalus and ventricular enlargement on computerized axial tomography (CT) of the head were evaluated using radionuclide cisternography and saline-infusion monometrics studies. The results of these tests were compared to evidence of atrophy on CT and clinical assessments of improvement after lumbar puncture or after ventriculoperitoneal shunt placement. Five patients received ventriculoperitoneal shunts. Four patients improved unequivocally after surgery. Of these patients all tests were consistent with the diagnosis of communicating hydrocephalus with the exception of moderate cortical atrophy present in the CT scan of one patient. One patient who failed to improve after surgery exhibited a markedly positive cisternogram prior to surgery, but a saline-infusion test was normal and the CT scan demonstrated cortical atrophy. In the 12 patients not receiving surgery the results of CT scans, saline-infusion tests, cisternograms, and improvement after lumbar puncture were compared. A close correspondence among these four parameters was found. In general no one test was significantly better than any other in predicting improvement after lumbar puncture or surgery, but all contributed to the workup. In light of past difficulties in establishing diagnostic or prognostic criteria for communicating hydrocephalus, it would be advisable to make use of as many diagnostic tests as feasible to clarify the diagnosis. ■

Brucella meningoencephalitis in childhood

Herbert M Swick, MD, Milwaukee, Wisconsin

Brucellosis is an uncommon disease in children, often relegated to the list of obscure causes of fever of unknown origin. Brucellosis does occur, however, and may present as a primary meningoencephalitis.

An 11-year-old girl developed intermittent fevers, chills, malaise and headaches. On admission several weeks later she appeared ill, with mild meningeal signs, papilledema, hyperactive deep tendon reflexes, and intention tremor. Routine studies and computerized tomographic (CT) scans were negative. Cerebrospinal fluid examination showed 175 white blood cells, glucose of 45%, and protein of 73%. All studies for bacterial, viral, and fungal agents were negative except for a brucella titer which rose from $<1:20$ to 1:320. Throughout the hospital course, malaise, chills, fever, and depression were prominent. The patient was treated with tetracycline with excellent response.

In the United States brucellosis occurs most frequently among abattoir workers, but may be seen in anyone exposed to unprocessed milk or infected animals. The protean but nonspecific

manifestations of brucellosis make diagnosis difficult. Neurologic signs may develop anytime during the course of illness. Meningitis, encephalitis, transverse myelitis, and neuritis may all occur. Ophthalmologic signs are fairly common, including keratitis, uveitis, papillitis, or papilledema. ■

Arnold-Chiari type III malformation

David B Frens, MD, Marshfield, Wisconsin

The Arnold-Chiari malformations are a series of four anomalies of posterior fossa structures commonly associated with hydrocephalus and occasionally associated with malformations in other organ systems. The type III anomaly occurs infrequently as compared with the other types. This report presented an infant who has the Arnold-Chiari type III malformation without accompanying hydrocephalus but with associated dextracardia and a cleft hand deformity. This case provided an opportunity to review the CT scan appearance of the type III anomaly, it adds to a small number of cases suggesting the secondary role of hydrocephalus in the Arnold-Chiari malformations, and it allows accurate timing of the gestational insult based on the timing of the gestational insult required to produce the associated anomalies. ■

Cough headaches

R Clarke Danforth, MD; Victor M Haughton, MD; Michael P McQuillen, MD; Glenn A Meyer, MD; and **Bhupendra Khatri, MBBS,** Milwaukee, Wisconsin

A 47-year-old white woman suffered three episodes of sudden onset of extremely severe excruciating headaches in seven days. Each of the episodes was preceded immediately by exertion. Routine tests, cerebrospinal fluid examination, and computerized tomographic (CT) scan of the head were normal.

A high resolution gastroenterologic scan and a computer assisted metrizamide cisternogram showed a lobulated mass in the right half of the tentorium near the incisura. Angiographic studies indicated the lesion in all probability was a meningioma.

In February 1979 the patient underwent a right post-temporal craniotomy with excision of right tentorial mass. ■

Percutaneous trigeminal thermal rhizotomy for trigeminal neuralgia

David E Ostrow, MD, Milwaukee, Wisconsin

Initially medical therapy for trigeminal neuralgia can offer relief of pain. However, with increasing age many of the patients become refractory to medication, developing excruciating pains of tic douloureux. Percutaneous trigeminal thermal rhizotomy is a new, highly effective form of treatment. The procedure is performed by introducing a needle electrode through the foramen ovale using radiologic control. The needle is located in the subarachnoid space retrogasserian to the ganglion. Final placement is confirmed in the conscious patient by electrical stimulation. Brief unconsciousness for the painful part is produced by using intravenous methohexital sodium (Brevital®). Successive radiofrequency lesions allow the production of a graded sensory deficit sufficient to relieve the pain while preserving touch and motor function in the face. The procedure is 80 to 90 percent successful for complete relief of pain. It overcomes the need for a prolonged general anesthetic with major surgery. The probabilities of permanent relief are high; and should it be necessary, the procedure is easily repeatable. ■

Tourette's syndrome

Stephen C Zinsmeister, MD, Marshfield, Wisconsin

Gilles de la Tourette's syndrome is a rare movement disorder often misdiagnosed as a nervous disorder and therefore inadequately and inappropriately treated. Georges Gilles de la Tourette first delineated the syndrome in 1885 but not until the 1940s was attention brought to the syndrome in the medical literature. Involuntary tic-like movements, echolalia, and at times corprolalia begin in childhood. A fluctuating insidious course is characteristic, persisting into adulthood.

CNS catecholamine imbalance has been implicated by findings of increased dopamine turnover. Haloperidol decreases tics whereas methylphenidate causes exacerbation. Uric acid and serotonin metabolism also have been implicated. Familial and sporadic cases occur.

Ten cases have been diagnosed at the Marshfield Clinic. Course and response to therapy have been variable. Much interest exists in establishing a Tourette's Society in Wisconsin. ■

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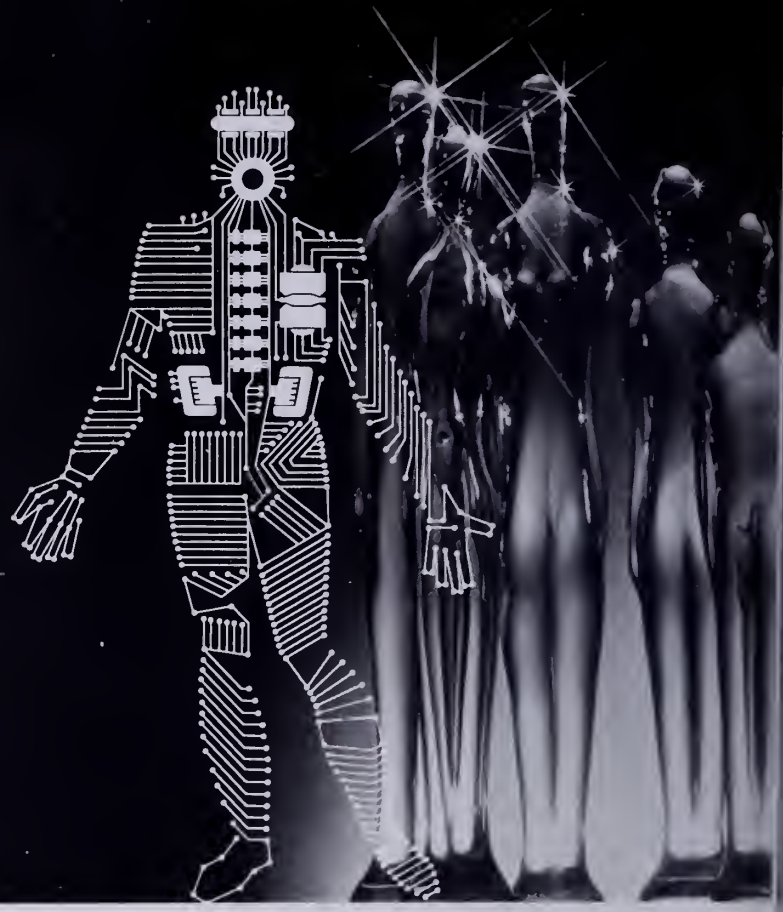

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Cancer Column

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AND ITS HEALTH SERVICES DIVISION

Bladder cancer etiology and synthetic carcinogens

Bladder cancer ranks sixth in the number of deaths and of new cases diagnosed each year in the United States. It is estimated that 26,000 men and 9500 women will develop bladder cancer and 7000 men and 3300 women will die of this type of cancer in 1980. About 300 new cases will be found in Wisconsin citizens. Bladder cancer has a special significance for the physicians and residents of Wisconsin, because Milwaukee, Ozaukee, Sheboygan, and Rock counties had significantly higher mortalities from this cancer than more rural areas of the state between 1950-1969; in fact some rural areas had fewer deaths than the average for the United States.

For more than 25 years, Dr George T Bryan and his staff at the Wisconsin Clinical Cancer Center have been engaged in a very broad and varied study of bladder cancer. Many collaborative projects have been established in areas of the world where there are people or animals who potentially have a high or low risk of developing bladder cancer. Over a thousand bladder cancer patients can be studied each year through contacts such as Doctors O Yoshida of Japan, H Wolf of Denmark, and T Nilsson of Sweden who previously worked at University Hospitals; Dr A M Pamukcu of Turkey who is adjunct professor in the Department of Human Oncology; and Dr A El-Aaser and Dr Nadia Higgy (presently a postdoctoral fellow at WCCC) of Egypt.

Recognized risk factors for bladder cancer are age, sex, occupation, smoking habits, and perhaps pelvic irradiation, coffee, and artificial sweeteners. Average age at the time of diagnosis is 68 years, but young people and animals appear more susceptible to bladder carcinogen exposure than mature or older ones. The incidence rate for men is 20.4/100,000 compared to 2.8/100,000 for women. Incidence appears to be decreasing in women, but it has increased over 20% in men.

Up to 80% of human bladder cancers may be directly attributable to environmental factors. It was the first human neoplasm for which a variety of precisely defined occupational and environmental chemicals were suggested as causal agents following chronic exposure. Since 1895 when Rehn found that men who manufactured the dye, fuchsin, had more bladder cancer, many studies have been done on relationships with other occupational chemicals. At least eleven different compounds have been associated with the development of human bladder cancer. None of these was part of our environment until after the middle of the 19th century. Some of the chemicals may be complete carcinogens, but others may be incomplete and act as initiators, promoters, or cocarcinogens. Probably more is now known and understood about the chemical causes of bladder cancer than of any other human tumor.

Only chemicals, not viruses or physical agents, have been shown to induce bladder cancer. People working with dyestuffs, rubber, leather and leather products, paint or organic chemicals have an increased risk of cancer of the lower urinary tract. There is a high incidence of bladder cancer in those exposed to aromatic amines such as 2-aminonaphthalene, benzidine, or 4-aminobiphenyl; certain aromatic nitro compounds such as nitronaphthalene or 4-nitrobiphenyl; or dyestuffs such as auramine, magenta, or fuchsin. The latent period from exposure to the development of cancer is 1-50 years (average about 18-20 years). The median age at which cancer is diagnosed is

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or the State Medical Society of Wisconsin, Health Services Division, PO Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

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Wednesday, May 14, 1980

starting at 3:00 pm CDT

Recently released data suggest that as many as 60 million Americans can be considered hypertensive. The diagnosis and long-term management of this large segment of our population represents a major health undertaking. The symposium is designed for primary care physicians who have responsibility for the care of patients with hypertension and other problems which increase cardiovascular risk. It will provide the scientific and clinical rationale for current approaches to the detection and management of hypertension, with special emphasis given to the ramifications of hypertension within a family setting. Two-way audio communication channels will permit members of the audience in the 19 cities to interact with the symposium panelists during the question and answer portions of the telecast. It will emanate from New Orleans, Louisiana, in association with the Seventh Scientific Program of the International Society of Hypertension. Participants in the symposium are members of the Editorial Board of *Dialogues in Hypertension.*

Registration—2pm/Program—3-6pm

CHICAGO

The First Chicago Center
The First National Bank of Chicago
Dearborn and Monroe
Robert M Kark, MD, Moderator

MINNEAPOLIS
Minneapolis Auditorium
1403 Stevens Avenue, South
Hiawatha Room
Ross M Tucker, MD, Moderator

Developed and produced by Health Learning Systems, Inc, under an educational grant from Smith Kline & French Laboratories, the symposium will provide the following accreditation:

- As an organization accredited for Continuing Medical Education, the American Heart Association designates this CME activity as meeting the criteria for 3 credit hours in Category I of the Physicians's Recognition Award of the American Medical Association.
- Acceptable for 3 prescribed hours by the American Academy of Family Physicians.
- Accepted for 3 hours of credit in Category I toward the certificate in CME in all United States state medical associations requiring it.
- This program is eligible for 3 hours credit in Category 2-B of the CME program of the American Osteopathic Association.

For further information, contact Health Learning Systems, Inc, Box 4243, New York, NY 10017 (Phone: 212/682-0705).

lower in cancers resulting from industrial exposure than in those occurring spontaneously.

Epidemiology of occupational bladder cancer is largely synonymous with the epidemiology of bladder cancers caused by exposure to arylamines. Approximately 20% of bladder cancer in men in some regions may be related to occupational arylamine exposure. These chemicals are used as reagents in the preparation of certain textile and hair dyes and paint pigments, as antioxidants in the preparation of rubber for tires and cables, and as curing agents in the manufacture of certain plastics. High-risk areas are associated with the chemical, rubber, and automobile industries near the New Jersey, Detroit-Akron, and Milwaukee-Chicago areas which use arylamines or arylamine-containing materials.

Dr Gerald Lower believes that N-acetylation of carcinogenic arylamines by human hepatic enzyme systems, genetic regulation of this enzyme activity, and enhanced susceptibility to arylamines in people with genetically distinct "slow acetylator" phenotypes may explain correlations between bladder cancer risk and the N-acetyltransferase phenotype in rural and urban populations.

Collaborative studies with Doctor Wolf in Denmark and Doctor Nilsson in Sweden showed that in Copenhagen arylamines appeared to play an etiologic role for "slow acetylators" who have about a 1.74 times higher relative risk than those who are "rapid acetylators." People who live in rural Sweden have a lower incidence of bladder cancer and show no differences in "slow acetylator" distribution, indicating a relative lack of involvement of arylamines in bladder cancer etiology in rural areas.

Certain drugs are also bladder carcinogens. Alkylating agents used to treat polycythemia vera and Hodgkin's disease patients have increased bladder cancer incidence. 5-Nitrofuran antibiotics used in the Middle East to treat urinary tract infections and in Japan as food preservatives produce bladder, breast, and bowel cancers in animals. And use of phenacetin analgesics has resulted in a high incidence of urothelial tumors of the renal pelvis, ureters, and bladder.

Artificial sweeteners such as cyclamates and saccharin and azo food dyes have likewise been implicated in the development of human bladder cancers. The debate about continued use of these substances by humans is continuing.

The next CANCER COLUMN will discuss some natural substances which can cause the development of bladder cancers.

—Dorothy J Buchanan-Davidson, PhD
Science Writer, WCCC ■

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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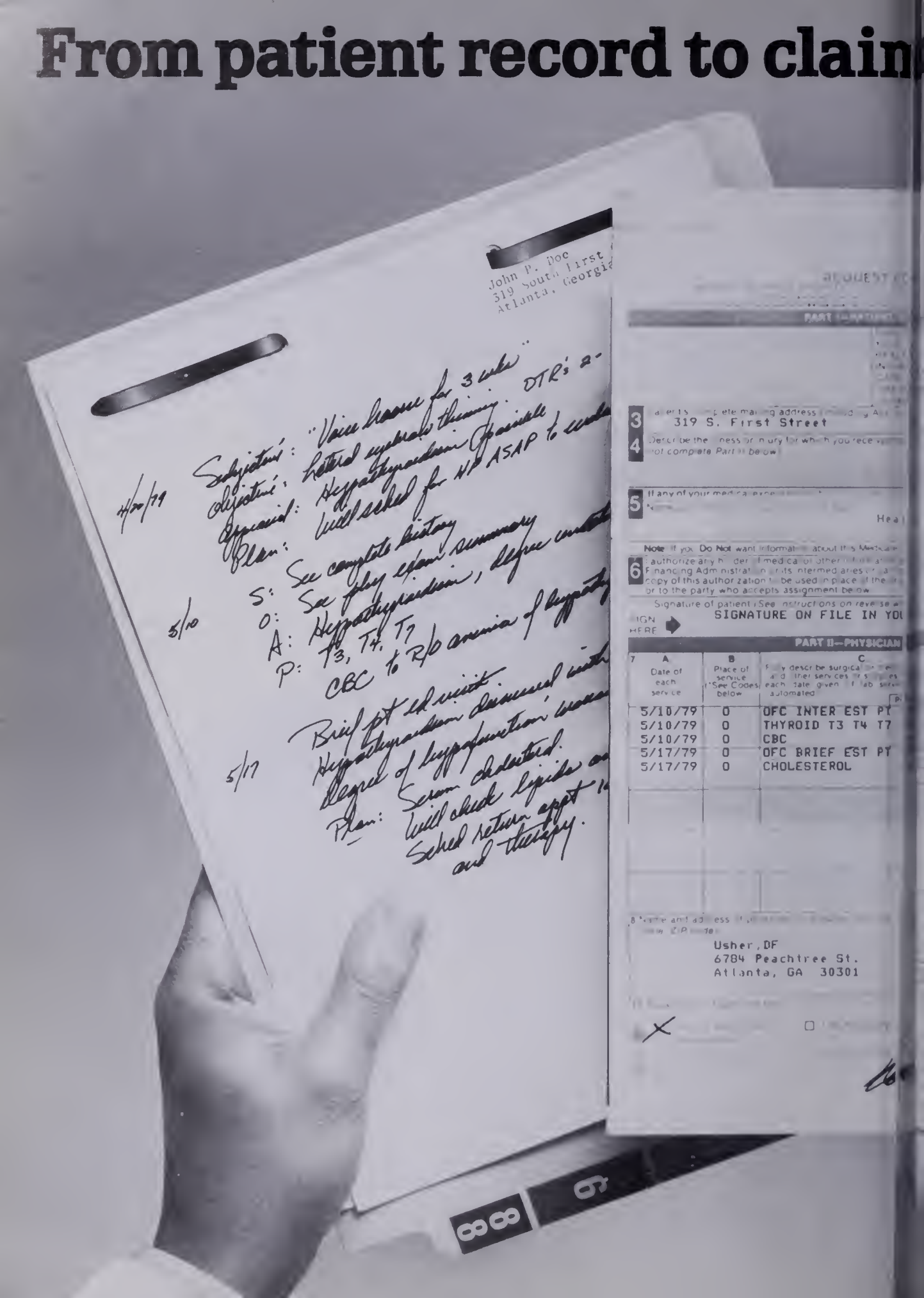
From patient record to clain



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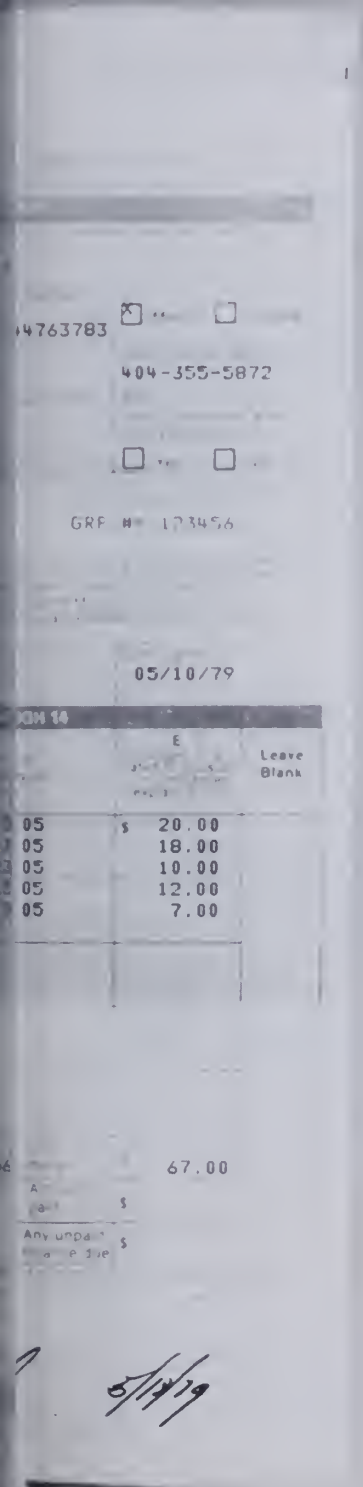

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THE NEW PRESIDENT
Russell F Lewis, MD

RUSSELL F LEWIS, MD, Marshfield obstetrician-gynecologist, was installed as the 125th President of the State Medical Society of Wisconsin, March 29, 1980, during the Society's Annual Meeting in Milwaukee. Doctor Lewis, 63, succeeds Darold A Treffert, MD of Fond du Lac.

A native of Edgerton, Doctor Lewis graduated from the University of Wisconsin Medical School in 1941 and served his internship at the University of Kansas. He served in the United States Army from 1942-1946 after which he joined the Marshfield Clinic medical staff. From 1951 to 1953 he served a residency in obstetrics-gynecology at the University of Wisconsin Hospitals in Madison. Doctor Lewis returned to the Marshfield Clinic at the end of his residency. He was president of the Marshfield Clinic in 1960, 1961, 1962-1966, 1967, 1968, and served as medical director in 1969-1977. He also served as a director of the Marshfield Clinic Foundation for Education and Research, 1958-1971.

Doctor Lewis is an active supporter of medical education as evidenced by his participation as a member of the Governor's Task Force on Medical Education in 1968 and the Kellett Commission for Education from 1969-1970. He presently is medical director of the Greater Marshfield Community Health Plan. He was a director of the University of Wisconsin-Stevens Point Foundation, 1967-1976. From 1967 to 1973 he was a member of the advisory committee to the Wisconsin Regional Medical Program, serving as its vice-chairman, 1969-1973. Since 1971 Doctor Lewis has been a member of the paramedical advisory committee to the Wisconsin State Department of Vocational, Technical, and Adult Education.

His dedication to organized medicine is reflected in the many groups to which he belongs: American College of Surgeons, American College of Obstetricians and Gynecologists, Central Association of Obstetrics and Gynecology, Wisconsin Society of Obstetrics and Gynecology, Group Health Association of America, American Academy of Medical Directors, American Group Practice Association, Wisconsin Professional Review Organization (WisPRO), and the North Central Area Health Planning Committee.

Doctor Lewis is a member and former chief of the Department of Obstetrics of St Joseph's Hospital in Marshfield. He served as Fourth District Councilor to the State Medical Society from 1971 until 1979 when he was elected president-elect. He has served on committees of the Wood County Medical Society and has been its delegate to the State Medical Society.

Not only is Doctor Lewis a leader in the medical community but also he participates in community groups including the Rotary Club, Chamber of Commerce, Community Chest (United Way), Elks Club, Airport Committee, and Greater Marshfield, Inc.

Doctor Lewis, whose wife died in 1974, has two children, Ann Margaret and Russell F Lewis, both of Marshfield. ■

Organizational SMS

Doctor Motzel to head SMS next year

A Waukesha physician, Albert J Motzel Jr, MD was elected president-elect of the State Medical Society of Wisconsin May 29 by its House of Delegates at the Annual Meeting in Milwaukee. Doctor Motzel, a surgeon, will assume the presidency at next year's Annual Meeting.

A graduate of St Louis University Medical School, Doctor Motzel has held several posts in organized medicine at state and county levels. He was president of the Waukesha County Medical Society in 1972-1973, and served as vice-speaker of the SMS House of Delegates from 1975-1976 and as speaker from 1976 to present.

In other House activities May 29, Russell F Lewis, MD, Marshfield, was installed as the 1980-1981 president succeeding Darold A Treffert, MD, Fond du Lac.

Duane W Taebel, MD, LaCrosse, was elected speaker of the House of Delegates, and Chesley P Erwin, MD, Milwaukee, was elected vice-speaker.

Reelected to serve as delegates to the American Medical Association for 1981 and 1982 were John K Scott, MD, Madison; Patricia J Stuff, MD, Bonduel; and DeLore Williams, MD, West Allis. Reelected to serve as alternate delegates for 1981 and 1982 were Richard W Edwards, MD, Richland Center; Cornelius A Natoli, MD, LaCrosse, and John D Riesch, MD, Menomonee Falls.

The House also confirmed the election of eight physicians to the SMS Council. Reelected as councilors were Carl Eisenberg, MD, Milwaukee; Pauline Jackson, MD, LaCrosse; John J Kief, MD, Rhinelander; Jung K Park, MD, Wisconsin Rapids; Timothy Flaherty, MD, Neenah, and Paul S Haskins, MD, River Falls. Elected as councilors were Roger Von Heimburg, MD, Green Bay, and Thomas A Hofbauer, MD, Menomonee Falls.

In final action, the House of Delegates:

- Retained unified membership (county-state-AMA) for another year. The vote (79 against—61 for) fell 14 short of the two-thirds needed to abolish the requirement. However, the issue will come before the House again in March 1981.
- Supported the use of tetracycline and erythromycin as well as silver nitrate to prevent blindness in newborns.
- Reaffirmed its 1979 position that nursing education programs continue to be developed at all levels in Wisconsin including degree schools, diploma schools, and schools for licensed practical nurses.
- Called for a repeal of the 1977 Wisconsin law which establishes a decertification program for specialized hospital services.
- Supported the concept of an "experienced teacher fellowship program" in school health education to prepare experienced Wisconsin teachers as master health educators.
- Opposed the concept of requiring physicians to take an exam for relicensure after a certain age and reaffirmed its support of the continuing medical education requirement for Wisconsin physicians. Currently, Wisconsin physicians must complete 30 hours of continuing medical education every two years.
- Officially declared marijuana to be a dangerous drug and a hazard to the public health.
- Reaffirmed the right of physicians to establish reasonable fees, individually, competitively and without interference and to ask Surgical Care-Blue Shield to refrain from advising its subscribers that they need not pay physician fees which exceed Surgical Care-Blue Shield payment allowances.

A summary of all House actions will appear in the May issue. ■

Doctor Treffert elected Council chairman

Darold A Treffert, MD, Fond du Lac, was elected chairman of the Council of the State Medical Society March 29 during the Society's Annual Meeting in Milwaukee. Doctor Treffert, who is the immediate past president of the Society, succeeds Paul S Haskins, MD, River Falls, as head of the Council (Board of Directors).

The Council reelected Timothy T Flaherty, MD, Neenah, vice-chairman; Richard W Edwards, MD, Richland Center, treasurer; EJ Nordby, MD, Madison; AA Quisling, MD, Madison, and HK Tenney, MD, Madison, assistant treasurers. Earl R Thayer was reelected secretary and general manager.

Reelected to serve as medical editor of the *Wisconsin Medical Journal* was Victor S Falk, MD, Edgerton. Wayne J Boulanger, MD, Milwaukee, was reelected editorial director. Editorial Associates reappointed for 1980 are Brenton H Field Jr, MD, Milwaukee; Raymond A McCormick, MD, DePere; TH McDonell, MD, Waukesha, and John P Mullooly, MD, Milwaukee. ■

Public relations ideas exchanged March 6

"I've discovered the news media are starving for medical help on stories," Richard Henry, MD, Chippewa Falls, told members of the SMS Commission on Public Information at its March 6 meeting in Madison. Doctor Henry and other Commission members shared ideas on how their respective county medical societies approached public information and media relations projects.

In the Eau Claire-Chippewa area, Doctor Henry explained that physicians have initiated a daily public service announcement program offering health and medical advice over two area radio stations. Area physicians volunteer to pretape the public service spots at the radio station and the spots then are aired during the prime "drive time" hours of 7-9 am and 4-6 pm each day.

Background material for the announcements is supplied by the AMA's Media Relations Dept, the physicians then edit them for local use, and insert the county medical society tag.

The program is very successful according to Doctor Henry. "We started the project with just one area radio station and soon another station approached us and asked if we would do a similar program for it."

When schools were reopening last fall, the Public Information Commission urged county societies to work with local school districts and media to see that as many children as possible were immunized. In response to this, Brown County physicians took out a newspaper advertisement offering "Pointers for Parents on Immunization." The ad also publicized the fact that physicians and others would be discussing the immunization program on a local television program that week.

Public Information Commission Chairman Herbert Sandmire, MD, Green Bay, said that Brown County physicians also have been successful in encouraging local media representatives to call them to comment on a breaking national medical story.

Doctor Sandmire says they are making headway in creating skepticism in the minds of reporters and editors to government news releases on health and medical care what he terms as "hit and run" release tactics of government.

On other matters March 6, the Commission voted to:

- Request principal SMS officers to participate in a series of public speaking engagements to civic groups in key media centers in the state. Such appearances are often covered by local media and could serve as an effective means by which to increase the public's awareness of the State Medical Society and its activities on behalf of patients.
- Go on record as supporting a proposed change to the SMS Constitution and Bylaws to allow medical students and first-year residents to become "candidate members" of the Society and that a medical students' section of the Society be created with one voting delegate and alternate delegate in the House of Delegates. The Commission further recommended to the Council that candidate membership benefits include, at a minimum, receipt of all regular communications including the *Wisconsin Medical Journal* and *Medigram*.

(The SMS House of Delegates was presented two resolutions dealing with medical student membership during its March 27-29 session. House action on these resolutions will appear in the May issue.) ■

WHCLIP Board sets new malpractice rates

The Board of Governors of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) in March approved a 15 percent reduction in physician malpractice premiums. The SMS Medical Liability Committee has been closely monitoring the financial status and experience of WHCLIP for several months and recommended the premium reduction. Through the efforts of Paul Jacobs, MD, Milwaukee, and Russell Quirk, MD, Racine, who serve on the WHCLIP actuarial committee as well as the SMS Medical Liability Committee, the 15 percent reduction was accepted.

According to the WHCLIP actuary, the rate reduction was possible because of a surplus which exists due to unused reserves collected in the early years of WHCLIP. The actuary did caution, however, that rates may need to be increased substantially in future years should the surplus become exhausted.

The 15 percent reduction will be applied to rates effective July 1, 1980.

On a more somber note, the Board of Governors also voted in March to recommend a 100 percent increase in Patients Compensation Fund fee assessments because the frequency and amount of claims penetrating the fund are increasing rapidly.

Due to the passage of Senate Bill 565, which represented a compromise measure reached by the SMS Physicians Alliance and the State Insurance Commissioner, and outlines administrative procedures for the fund, fee assessments are now subject to legislative review and approval.

Public hearings on the 100 percent fund fee assessment were to be held April 16. SMS actuaries are in the process of evaluating fund experience to determine whether a 100 percent increase is justified. SMS representatives were to testify at those public hearings. Legislative hearings are not anticipated until May.

Physicians should note that even if the 100 percent fund fee assessment increase goes into effect, physicians insured by WHCLIP will realize some savings as the 15 percent WHCLIP reduction offsets the fund increase. For example, a general practitioner insured by WHCLIP will save $40 over last year's total (WHCLIP plus fund) payment and a neurosurgeon insured by WHCLIP will save $400 overall. ■

Medical Society points out flaws in Health Plan

"While the 1980 Wisconsin State Health Plan represents a significant improvement over the 1978 plan, it is flawed by the rigid and inappropriate application of the Federal Guidelines for Health Planning and this could result in the loss of needed open heart, neonatal intensive care, and computed axial tomography services in some areas of the state," a Commission of the State Medical Society of Wisconsin charged last month.

The Society's Commission on Health Planning, chaired by Guenther Pohlmann, MD, Milwaukee, issued its comments in conjunction with several public hearings being held throughout the state in March by the State Health Policy Council to review the proposed 1980 State Health Plan. Sixteen physicians representing the State Medical Society and medical specialty groups testified at the hearings.

The State Health Plan is a broad policy document which assesses the status of healthcare services provided to Wisconsin residents and makes recommendations regarding the improvement and efficient distribution of those services.

"New amendments to the Federal Health Planning Law require that state health plans 'take into account' the National Guidelines for Health Planning," the Commision explained. "Yet almost every section of the plan strictly adheres to federal numbers which in many cases are inappropriate for Wisconsin."

For example, the proposed State Health Plan calls for all adult open heart surgery programs to perform a minimum of 200 procedures per year in order to be consistent with the national guidelines.

"If this goal were to be met in Wisconsin, it would mean the loss of 11 of the 18 open-heart surgery programs currently operating in Wisconsin," the Commission noted.

The plan further recommends amending Wisconsin's certificate-of-need law to be consistent with the federal guidelines and require each computed axial tomography (CAT) scanner to perform 2,500 procedures per year. Currently, 19 of the state's 26 CAT scanners could meet this requirement. And if the definition of what constitutes a procedure were changed to comply with federal guidelines as is currently proposed, even fewer facilities operating CAT scanners would meet the requirement, according to the Commission.

"The planning process fails to recognize the importance of computed tomography scanning and what it can do to actually reduce healthcare costs," the Commission said.

"CAT scanners have replaced the more costly and often painful diagnostic procedures such as pneumoencephalograms and myelograms used to diagnose brain tumors and herniated disc disease."

The doctors also pointed to the fact that many diagnostic procedures commonly occur on an outpatient basis as a result of CAT scanning, thereby reducing patient trauma and the higher cost of hospitalization considerably.

"Obviously, new, cheaper, and more efficient modalities of the CAT scanner will be discouraged if the national guidelines are applied to Wisconsin," the Commission stated.

The physicians objected to the planners' insistence in distinguishing between "Level I, II, and III" hospitals under the Obstetrical-Perinatal Services Section of the plan when neither the State Health Plan nor the federal guidelines have specified what constitutes a Level I, II, or III hospital.

The plan currently requires 1500 annual deliveries and a 75 percent average occupancy rate for each obstetrical unit for each Level II and Level III OB unit and also requires that each neonatal service area in the state has no more than 4 beds per 1000 live births.

"There is no clear medical basis for distinguishing between 'Level I, II, and III' hospitals," the Commission pointed out. "While we agree that theoretically only complicated pregnancies should be handled in hospitals which can offer the appropriate level of care, it is impossible to play the numbers game with OB units. The state cannot predict when there will be a certain amount of a certain type of delivery," the Commission said.

"We challenge the health planning agencies to defy the nature of pregnancy by accurately planning for when babies will arrive!"

The State Medical Society's Health Planning Commission expressed its support for improved sections of the Plan relating to Jail Health Care, Environmental Health, Vision Care, Community Health Education, and Occupational Health and Safety. The State Health Policy Council is expected to act on the proposed plan in April. ■

Delay asked in decertification rule process

SMS Secretary Earl Thayer has asked Donald Percy, secretary of the State Dept of Health and Social Services, to delay submitting the decertification rule on open heart cardiac catheterization services to the legislative review process until the technical advisory committee charged to assist in the rule development has had full opportunity to review the draft and suggest changes.

Thayer said the Society and its Health Planning Commission felt the rule contained provisions which were outside of enabling statutory authority and that it lacked specificity. State drafters of the rule have chosen "need" (defined as capacity rather than demand) as the primary criterion in making decertification decisions. Physician members of the technical advisory committee have said "quality" should be the primary factor in decertification decisions.

If the rule is adopted as drafted, each cardiac surgery room would have to average approximately 500 open heart surgery procedures per year (200 procedures could be subtracted from a hospital's total requirement) and each cardiac catheterization laboratory would have to perform 720 procedures a year to avoid being selected for decertification review. Currently, only 3 out of 18 open heart programs in the state would survive the test. ■

Medicaid budget receives Finance Committee okay

The Legislature's Joint Committee on Finance in March approved the major portions of the Annual Budget Review Bill, AB 1180, dealing with adjustments to the Medicaid program. The Legislature was to finish its work on AB 1180 before its adjournment on April 2. The Finance Committee approved a series of recommendations prepared by the Human Resources Subcommittee including:

- A mandatory second opinion program for a series of surgical procedures. Earlier Senator Paul Offner (D-LaCrosse) had suggested an opinion program with 13 specific procedures which would require a second opinion before Medicaid would pay claims for the services.

The full committee, however, made a series of changes to that earlier proposal by: (1) creating the second opinions as a pilot program due to expire in early 1982 unless extended by the Legislature; (2) granting authority to DHSS to identify the surgery requiring a second opinion by administrative rule rather than "listing" the procedures in the statutes; and (3) permitting the recipient to decide whether to proceed with the surgery; *ie,* a second opinion would be necessary but in the event of conflicting opinions, the patient would then decide whether to proceed and reimbursement would not be affected.

While SMS has a long-standing policy against second opinions, SMS has stated that in any event, patients should not be liable for the cost of the opinion. The opinion program is designed to save about $500,000 per year, and a one-time start up cost of $50,000 was included in the proposal. The cost of the opinions would be borne by the Medicaid program and HEW has committed funds to pay 75% rather than the traditional 60% of the pilot program.

- A directive that DHSS report to the Finance Committee by year's end on the methodology employed by DHSS to determine physician reimbursement in Medicaid and to recommend steps to eliminate "parity" problems which exist between urban and rural physician reimbursement. This action does not change reimbursement but only requires that recommendations for possible future changes be made.
- Adoption of a "case management" study by DHSS due on Sept 1, 1980. This study would outline suggestions for alternative recipient enrollment strategies and for methods of addressing provider participation including fee-for-service reimbursement or capitation fees. A review of the "primary provider" concept was also requested.
- A requirement that DHSS report to the Finance Committee before any extension to existing or future claims processing contracts are made. The Finance Committee also required that EDS-Federal be paid for processing under a "sum-certain" appropriation rather than a "sum-sufficient" to pay the cost of processing. ■

Legislative update

Here is a brief summary of legislative action taking place just prior to the Legislature's adjournment April 3:

- Assembly Bill 913, which establishes a new standard for involuntary commitment under the Mental Health Act, received final approval of both Houses and is now awaiting the Governor's signature. The State Medical Society supported the bill upon recommendation by the Society's Mental Health Committee.
- Assembly Bill 246, which permits Emergency Medical Technicians, under the direction of a physician, to provide treatment (including injection) for anaphylactic shock passed the Senate on a vote of 29-0. The bill has now gone to the Governor for his signature.
- Assembly Bill 780, which requires a six dollar deductible for emergency room services on all health insurance policies, was recommended for passage by the Assembly Health and Social Services Committee. However, the bill was never scheduled for debate and died upon the Legislature's adjournment. Medicaid and supplemental Medicare policies were excluded from the bill. SMS supported the bill in principle providing the deductible be extended to Medicaid.
- Assembly Bill 279, which would permit physicians to prescribe marijuana or its derivative, THC, for persons suffering from glaucoma or the side effects of cancer chemotherapy and radiotherapy treatments, was recommended for passage by the Legislature's Joint Finance Committee. This bill also was not scheduled for debate and died at session's end. SMS opposed the bill since the Controlled Substances Board already has the power to approve the use of marijuana for medical research purposes.
- An amended Assembly Bill 1132, providing a legal recognition of brain death in Wisconsin, was defeated in the Senate on a 19-10 vote. SMS had supported the measure which had passed the Assembly a few weeks earlier.
- Senate Bill 400, which would establish a mandatory risk-sharing plan for persons unable to obtain conventional health insurance coverage, passed the Assembly on a 92-3 vote. SMS has supported "insurance for uninsurables" legislation such as this for the past two legislative sessions. The Wisconsin Chiropractic Association, however, was successful in adding an amendment to the bill to include chiropractic coverage in the risk-sharing plan. The bill, with this amendment, received Senate concurrence and has been sent to the Governor. SMS vehemently opposed the chiropractic amendment. ■

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of February 18, 1980

NEW MEMBERS

County Medical Society

DANE

Ansfield, Thomas J, 4410 Regent St, Madison 53705 (1940, Regular, Internal Medicine/Cardiovascular Diseases)
Baranowski, Walter, 1912 Atwood Ave, Madison 53704 (1937, Regular, Orthopedic Surgery, Certified)
Byrd, Janis E, 1320 North Bristol St, Sun Prairie 53590 (1943, Regular, Family Physician, Certified)
Carlson, Sheila K, 3905 Paunack Ave, Madison 53711 (1951, Regular, Urology/General Surgery)
Cole, Robert L, 5714 Odana Rd, Madison 53711 (1947, Regular, Family Physician)
Contreras-Trejo, Mario R, Dept of Pathology, 36 S Brooks St, Madison 53715 (1948, Resident, Pathology)
Diem, Klaus D, 20 S Park St, Suite 307, Madison 53715 (1949, Regular, Obstetrics and Gynecology)
Godfrey, Charles B, 158 State St, Oregon 53575 (1950, Resident, Psychiatry)
Kaufman, Laryssa N, 125 South Owen Dr, Madison 53705 (1950, Resident, Internal Medicine)
Rich, Frederick M, 2914 Oxford Rd, Madison 53705 (1927, Regular, Radiology, Certified)

GRANT

Kantamneni, Maruthi, 1370 North Water St, Platteville 53818 (1938, Regular, Internal Medicine/Cardiovascular Diseases)
Stader, Robert E, 235 North Madison St, Lancaster 53813 (1948, Regular, Family Physician)

MARATHON

Beier, James J, 607 13th St, Mosinee 54455 (1944, Regular, Family Physician, Certified)
Gabriel, Youssef H, 2727 Plaza Dr, Wausau 54401 (1941, Regular, Neurological Surgery)

OUTAGAMIE

Gmeiner, James G, RR #2, Wagon Wheel Trail, Appleton 54911 (1948, Regular, Orthopedic Surgery/General Surgery)
Hall, Marvin L, 612 East Longview Dr, Appleton 54911 (1949, Regular, Ophthalmology)
Keane, Keith M, 610 East Longview Dr, Appleton 54911 (1920, Regular, Psychiatry, Certified-PN)

PORTAGE

Jones, Lawrence D, 1800 North Point Dr, Stevens Point 54481 (1928, Regular, Occupational Medicine)

RICHLAND

Edmonson, M Bruce, 1313 W Seminary St, Richland Center 53581 (1948, Regular, Pediatrics)
Sinnett, Dale F, Rte #2, Box 32A, Richland Center 53581 (1947, Regular, Internal Medicine)

SHAWANO

Craft, George A, PO Box 447, Keshena 54135 (1944, Regular, Family Physician/Psychiatry)

WAUKESHA

Banasiak, Michael F, 17050 West North Ave, Brookfield 53005 (1943, Regular, Internal Medicine/Endocrinology, Certified-IM)
Dall, James E, 1111 Delafield St, Waukesha 53186 (1948, Regular, Family Physician)

WINNEBAGO

Hinchen, James E, 400 Ceape Ave, Oshkosh 54901 (1947, Regular, Family Physician, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Nepple, Earl W, Dallas, Tex, to 1105 E Ponderosa Parkway, Flagstaff, Ariz 86001

GREEN

Paull, Laurence G, Monroe, to 1910 North 122nd Ave, Seattle, Wash 98133

DEATHS

Nuzum, Thomas O, Rock County, Jan 19, 1980
Rawlins, Joseph A, Walworth County, Jan 20, 1980
Peterson, John C, Milwaukee County, Jan 29, 1980
Pomainville, Harold G, Wood County, Feb 4, 1980 ■

Obituaries

◇County, State, AMA Members

◇ **Thomas Ochsner Nuzum, MD,** 78, Janesville, died Jan 19, 1980 in Janesville, Born Oct 3, 1901 in Brodhead, he graduated from Rush Medical College, Chicago, in 1926 and did postgraduate work in internal medicine at the University of Vienna in Austria. Doctor Nuzum was associated with the Pember-Nuzum Clinic until his retirement in 1966. He also served as a pathologist at Mercy Hospital and was medical director of the Rock County Sanatorium from 1928 to 1942. He served in the United States Army Medical Corps for four years during World War II and was elected to the Janesville Board of Education for several terms after his return. Surviving are his widow, Dorothy; two sons, Thomas of Seine, France, and Richard, Toledo, Ohio; four daughters, Mrs Edward Weston, Terre Haute, Ind; Mrs John Burchard, Burlington, Vt; and Mrs Robert Parker and Mrs John Mueller, both of Janesville.

◊ **Joseph A Rawlins, MD,** 71, Elkhorn, died Jan 20, 1980 in Madison. Born May 24, 1908 in Kewaunee, Ill, Doctor Rawlins graduated from Northwestern University Medical school in 1933 and served his internship at Milwaukee County General Hospital and Cook County Hospital in Chicago. He had practiced medicine in Elkhorn since 1938 and retired from his medical practice in 1976. Surviving are his widow, Charlotte; a son, Dr Steven Rawlins, Beaver Dam; and a daughter, Mrs James (Joanne) Clinton of Whitefish Bay.

◊ **John Cyril Peterson, MD,** 75, former chief of pediatrics at Milwaukee Children's Hospital and former head of the Department of Pediatrics at the Medical College of Wisconsin, died Jan 29, 1980 in Point Washington, Fla. Born Nov 11, 1904 in Lehi, Utah, Doctor Peterson graduated from Vanderbilt University School of Medicine, Nashville, Tenn, in 1931. His internship was taken at Western Reserve Medical School, Cleveland, Ohio, and his residency training in pediatrics was completed at Vanderbilt University School of Medicine. Doctor Peterson taught bacteriology and immunology at Cornell Medical School, New York, from 1935-1938. He taught at Vanderbilt until 1953 when he was named to head the Department of Pediatrics at the Medical College of Wisconsin, Milwaukee, a position he maintained until 1974. Doctor Peterson retired in 1977, making his final rounds as staff professor in July. Surviving are his widow, Ruby; three sons, John, Fresno, Calif; Brent, Whitefish Bay, and Neill, Chicago, Ill.

Ambrose B Kores, MD, 67, Beaver Dam, died Jan 30, 1980 in Beaver Dam. Born Feb 21, 1913 in Beaver Dam, Doctor Kores graduated from Marquette University School of Medicine in 1942 and served his internship at Milwaukee County General Hospital. He served with the United States Army Medical Corps from 1943 - 1946 during World War II.

Sushil K Eric Mukand, MD, 48, Neenah, died Feb 4, 1980 in Neenah. Born July 12, 1931 in Agra, India, Doctor Mukand graduated from King George Medical College in India and practiced there from 1955 - 1970. He served his internship at St Luke's Hospital, St Paul, Minn. Surviving are his widow, Ivy; one daughter, Sushma; and two sons, John A and Timothy.

◊ **Harold G Pomainville, MD,** 72, Wisconsin Rapids, died Feb 4, 1980 in Wisconsin Rapids. Born May 18, 1907 in Waumandee, he graduated from Temple University School of Medicine in Pennsylvania and served his internship at Milwaukee County General Hospital. Doctor Pomainville practiced in Wisconsin Rapids from 1945 until his retirement in 1976. He was Wood County coroner for many years and also served as city health officer. He was a fellow of the American College of Obstetricians and Gynecologists. Surviving are his widow, Bernice; two sons, Harold, Madison, and Dr Charles, Wisconsin Rapids; one daughter, Suzanne, Dallas, Tex; two brothers, Dr Leland, Wisconsin Rapids, and George, Boulder, Colo; and one sister, Carol Buehler, Nekoosa.

◊ **William Donald James, MD,** 73, Oconomowoc physician for 43 years, died February 21, 1980 in Oconomowoc. A dedicated physician of organized medicine, Doctor James served as the president of the State Medical Society of Wisconsin in 1968-1969. He previously had served as councilor from the First District, 1954-1967, and as president of the Waukesha County Medical Society. Most recently he had served as a member of the State Medical Society's Commission on Peer Review, 1977-1980.

For many years Doctor James was Wisconsin chairman of the AMA-ERF committee and served as a medical advisor to the American Association of Medical Assistants, Inc-Wisconsin Society. He also was a member of the Title XIX Advisory Committee to the State Department of Health and Social Services and served on the DHSS Board.

Born Oct 17, 1908 in Evanston, Illinois, Doctor James graduated from Lawrence College, Appleton, in 1927. He taught school for four years before entering the University of Wisconsin Medical School, Madison. After graduating in 1935, he served his internship and residency training at Milwaukee County General Hospital. Doctor James started his medical practice in Oconomowoc in 1937, and from 1941-1946 he served in the United States Army Medical Corps. He resumed his practice in Oconomowoc and served as city health officer for several terms.

When Doctor James closed his office practice in 1973, he became medical director of the Masonic Home in Dousman. Doctor James was a charter member of the Academy of Family Physicians. Surviving are his widow, Ramona; one son, Charles of Oconomowoc; and a daughter, Mrs Peter (Sue) Prime, also of Oconomowoc. ■

NEWS YOU CAN USE

INVESTMENT/PRACTICE MANAGEMENT SEMINAR PLANNED. On Friday, June 13 and Saturday, June 14, SMS Services, Inc will present an outstanding seminar on *Planning for Profit.* The program covers both personal financial planning including current investments, retirement programs, and estate planning together with practice management planning with emphasis on cash flow, sources of capital, cash management, and corporate structure. The place: Olympia Resort, Oconomowoc. Spouses are welcome. For details contact Peter Wood at SMS headquarters in Madison: 257-6781 or toll-free 800-362-9080, ext 144. ■

County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

County society works to reduce healthcare costs

Sure everyone who has looked at a newspaper lately knows that healthcare costs are increasing at an alarming rate. But what can be done about it? Government officials, insurance companies, and healthcare providers have been arguing over the answer to this question for months now. While they were busy talking about the problem, however, Brown County physicians were trying to solve it.

Last year, physicians in the Brown County Medical Society approved a plan recommending 65 cost-saving measures that affect doctors, nursing homes, patients, hospitals and pharmacies.

The plan, developed by the Society's Cost Containment Committee chaired by Jeremy Green, MD,* Green Bay, was sent to all Brown County Medical Society members with a letter encouraging them to implement the recommendations listed.

"Physicians control expenditures and direct where patients go; therefore, we are responsible in large measure for this cost problem," Doctor Green said.

"Cost containment requires a conscious and sometimes time-consuming effort on the part of every physician, and the only reward is the personal satisfaction that we at least have tried to reduce the cost of healthcare in our community," he said in a letter to Brown County physicians accompanying the recommendations.

A complete list of all 65 recommendations that physicians can use to cut healthcare costs in their communities is available from the Brown County Medical Society who encourages other Wisconsin physicians to take the initiative and implement them in their respective communities. ■

AMA medical speakers competition underway

The AMA Speakers Bureau is coordinating the third national competition for physician speakers who represent their state or county medical society in seven categories. These categories include: Television News Show, Television Talk Show, Radio News or Talk Show Guest, The Physician as TV or Radio Host, Public (lay) Audience Speech, Professional Audience Speech, and Testimony. Any physician selected by his or her county or state medical society is eligible to submit an audio or video cassette tape entry for one of the audience categories. Submit one standard size audio or 3/4" video cassette tape for any or all of the seven categories postmarked no later than November 15, 1980 and send to Mr Mort Enright, Director, AMA Speakers & Leadership Programs, 535 N Dearborn St, Chicago, Ill 60610. The speaker must have officially represented the medical society for one of the seven audience types between Nov 16, 1979 and the November cutoff date. For further details or applications, contact Diane Upton, Communications Coordinator, at SMS headquarters in Madison. ■

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Louis R Rosin, MD,* Superior, recently was appointed an associate professor of family practice at the Medical College of Wisconsin and program director of the family practice residency program at St Mary's Hospital in Milwaukee. An alumnus of the Medical College, Doctor Rosin has been in private practice in Superior since completing his internship in 1953. While in private practice he has taught medical students from both Wisconsin medical schools and the University of Minneapolis-Duluth for 15 years.

Henry M Goldberg, MD,* Milwaukee, director of the Milwaukee Industrial Clinics, recently received the 1979 Meritorious Service Award from the Governor's Committee for People with Disabilities. Doctor Goldberg, whose specialty is industrial medicine, also is on the board of directors of the Medical College of Wisconsin.

David B Tange, MD* and **Mary Jo Freeman, MD,*** Mosinee, recently were certified as diplomates of the American Board of Internal Medicine. Doctor Tange attended Albert Einstein College of Medicine, New York, and served his residency at Mt Sinai in Milwaukee. Doctor Freeman graduated from the University of Wisconsin Medical School, Milwaukee, and also served her residency at Mt Sinai. A husband and wife team, they staff the Kronenwetter Clinic in Mosinee.

Edward Eschenbaum, MD, Rice Lake, recently opened his office for the practice of urology. He graduated from the University of Illinois Medical School, served an internship at Rockford Memorial Hospital in Illinois, and did graduate work at the Medical College of Wisconsin. He also served in the United States Army Medical Corps in Vietnam. Prior to coming to Rice Lake, Doctor Eschenbaum was affiliated with hospitals in Wausau and Decatur, Ill.

Norman J Schroeder, MD,* Beaver Dam, recently was elected into active membership by the American Society for Gastrointestinal Endoscopy.

Patrick M Healy, MD, St Paul, Minn, recently opened his medical practice of orthopedic surgery in Rice Lake. He is associated with Roger Branham, MD,* and is on the medical staff of Lakeview Medical Center. He graduated from the University of Wisconsin School of Medicine, Madison, and also completed his residency in orthopedic surgery at the University. He is certified by the American Board of Orthopedic Surgery.

James E Auer, MD,* Elm Grove, recently was honored as "Humanitarian of the Year" by the Save-A-Heart Foundation at its eighth annual membership dinner. Doctor Auer graduated from the University of Iowa Medical School and in 1970 joined Samuel Kalush, MD,* in the practice of cardiovascular surgery. A fellow of the American College of Cardiology, Doctor Auer was the first in the Milwaukee area to use the microscope for coronary bypass surgery.

Alois Proett, MD and **George Fleming, MD,*** physicians affiliated with Eau Claire Orthopedics, Ltd, recently started outpatient clinics at Chippewa Valley Area Hospital in Durand. Doctor Proett graduated from the University of Nebraska, Omaha, where he also completed his orthopedic residency. Doctor Fleming graduated from the University of Illinois Medical School and completed his orthopedic residency at the University of Minnesota Hospital.

William F Schorr, MD,* Marshfield, was selected to receive the coveted Murray Gruber Award for presenting the outstanding scientific program to nearly 300 peers during an international dermatology conference. The conference, held in Hawaii in 1979, is sponsored annually by the University of California (San Francisco), Northwestern University, and Cleveland Clinic. Those in attendance select by ballot the presentor who provides, in their judgment, the most effective educational program during the four-day annual seminar. The award and plaque will be accepted on Doctor Schorr's behalf by Henry H Roenigk, MD of Northwestern University Medical School during the 1980 conference, also in Hawaii.

James D Michael, MD,* Sheboygan internist, recently received a first place award in the 42nd annual art exhibit of the American Physician's Art Association for his watercolor painting, "Sand Castles."

C Norman Shealy, MD,* director of the Pain and Health Rehabilitation Center in LaCrosse, was the keynote speaker at the opening session of a seminar on pain held March 19-21 in San Francisco. Sponsored by the President's Committee on Employment of the Handicapped, the American Psychiatric Association, the Menninger Foundation, and the American Hospital Association, the seminar considered the individual, social, and economic cost of pain in American society today. Seminar participants reported that pain is an annual $50 billion factor in the US economy. "According to studies, the cost of pain—in dollars lost, in production spoilt, in insurance claims, and medical and drug bills—runs to $50 billion annually and to 700 million workdays in time lost."

Daniel T Kincaid, MD,* cardiologist and nephrologist at the Midelfort Clinic, Eau Claire, recently announced his candidacy for the Eau Claire Area School Board. He graduated from the Johns Hopkins University School of Medicine, Baltimore. He is a member of the medical staff of Luther and Sacred Heart hospitals and also is a volunteer faculty member in the Eau Claire Family Practice Residency Program.

Richard E Martin, MD,* Two Rivers physician for almost 50 years, has retired from his medical practice. In his retirement, Doctor Martin plans on continuing with his interests in bowling, fishing, and golf.

Jules D Levin, MD,* Milwaukee, recently was elected president of the Milwaukee Rotary Club. A past president of both the Milwaukee County Medical Society and the State Medical Society of Wisconsin, Doctor Levin continues to be active in community affairs as well as medicine.

Walter Lewinnek, MD,* Merrill, was elected president of the American Cancer Society/Wisconsin Division at its Annual Meeting held in October 1979 in Stevens Point. A physician in family practice, Doctor Lewinnek has been involved with the American Cancer Society since 1952. He devotes much time to professional education at the local and state level. Doctor Lewinnek succeeded Henry Pitot, MD, PhD, director of McArdle Laboratory for Cancer Research, Madison. Doctor Lewinnek has served as medical director for a 12-county area since 1971 and various other offices of the Society, including chairman of the executive and public education committees.

Edwin L Bemis, MD,* Milwaukee pathologist, recently received the "Master of Excellence" award in the 42nd annual art exhibition of the American Physician's Art Association. His painting, "Autumn Glory," depicts a scene he saw while driving along a deserted country road near the Wisconsin Dells where he has a summer home. Doctor Bemis, who is deputy director of Deaconess Hospital in Milwaukee, is well known throughout the country for his artistic achievements. He has received numerous awards for his acrylics and for his color photography. This year Doctor Bemis' color photograph of urate crystals was selected for use on the cover of ***Pathology,*** the journal of the College of American Pathologists.

William Hopkins, MD, will be joining the Owen Medical Center in June. Doctor Hopkins, a family practitioner, graduated from the George Washington University Medical School, Washington, DC in 1977 and is completing his family practice residency at the University of Minnesota Hospitals, Department of Family Practice, in Minneapolis.

Timothy Devitt, MD, Soldiers Grove, has joined the part-time faculty of the Mayo Clinic Family Practice Residency Program in LaCrosse. Doctor Devitt is a member of the Kickapoo Valley Medical Clinic. He has been in practice in Soldiers Grove since 1976 and plans on continuing his practice there.

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Wausau Medical Center recently held a joint Social/Scientific Meeting with the medical staff of the Marshfield Clinic. The scientific program was presented by three physicians from the Marshfield Clinic. Marvin Kuehner, MD* spoke on "Gastric Bypass," James Opitz, MD* spoke on "New Developments in Neonatology," and Bruce Fye, MD* presented a program entitled "Two Dimensional Echocardiography—A Major Advance in Cardiac Diagnosis." The meeting represented a series of joint cooperative educational exchange programs between the Wausau Medical Center medical staff and the Marshfield Clinic physicians

State Laboratory of Hygiene, Madison, recently announced confirmation of the appointment of Ronald H Laessig as its new director by the University of Wisconsin System Board of Regents. Laessig has been serving as acting director since Stanley L Inhorn, MD* announced his intention to step down from the post following his appointment as pathology department chairman in July 1978. Laessig received a bachelor's degree in chemistry from UW-Stevens Point in 1962 and a doctorate in analytical chemistry in 1965 from UW-Madison. He did postdoctoral work at Princeton University and has had in-residence training at the Communicable Disease Center, Atlanta, Georgia. He is a professor of preventive medicine at UW-Madison.

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Deaconess Hospital, Milwaukee, has promoted John H Reising of Shorewood to vice president—general services and health planner, according to Kenneth S Jamron, president. Reising, formerly assistant administrator—general services and health planner, was given the new title in recognition of his increased responsibilities within his job area, Jamron stated. Before joining Deaconess in 1976, Reising worked in several capacities with the Comprehensive Health Planning Agency of Southeastern Wisconsin. He was involved with developing areawide medical services guidelines for cardiac catheterization and surgery, radiation and renal dialysis. Holding a master's degree in hospital administration from Duke University, Reising has been a member of the American College of Hospital Administrators since September 1976.

Marshfield Clinic, Marshfield, recently announced election of Nelson A Moffat, MD* as its new president, succeeding Ben R Lawton, MD.* The new slate of officers also includes MDs Cesar N Reyes, vice-president; J Douglas Lee,* secretary; and William J Maurer,* treasurer (reelected). Others elected to complete the Executive Committee are MDs Ben R Lawton,* Frederic P Wesbrook* (second term), William V Dovenbarger* and Jerry M Hardacre* (both having previously served on the committee), and Paul S Treuhaft* (second term).

Smith Kline & French Laboratories has announced that one of its medical representatives, Jagdish J Shastri of Milwaukee, was given the professional designation of CMR (Certified Medical Representative). Shastri was one of 50 representatives receiving the honor. A diploma will be awarded at a later date. The CMR designation is awarded by The Certified Medical Representatives Institute, Inc of Roanoke, Virginia upon completion of a two-and-a-half year home study program. All course study is related to the career functions of representatives of ethical drug manufacturers and is the equivalent of some 600 college hours, primarily in the medical sciences. Shastri attended Concordia College from 1973 to 1976 and holds a BSC (Chemistry) and BBA (marketing and sales) degree. In Milwaukee he is active on the Board of Directors of the India Cultural Society of Milwaukee. ■

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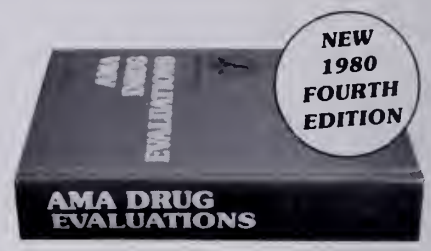

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Pediatrician: Join five-doctor department and 18 physician multispecialty clinic in Appleton, Wis. Basically primary care with teaching opportunity. Excellent hospitals. Guarantee and incentive compensation. Complete benefit package. Medium size community with excellent education, cultural, recreation, and shopping opportunities. Contact David W Boardman, Medical Arts Clinic, SC, 401 North Oneida St, Appleton, Wis 54911, telephone 414/739-0171. 4-6/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Ideal practice opportunities. 50-man multispecialty group with openings for:

- 1-2 Orthopedic Surgeons
- Urologist
- Psychiatrist
- Family Practice
- Neurosurgeon

Prestigious medical group. Perfect location for good family living, 45 minutes from Madison and 90 minutes from Milwaukee. For details contact Robert E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 (Phone collect: 608/328-7000). 3-7/80

Gynecologist needed for a primary care group of 10 physicians in northwestern Wisconsin. New 75-bed hospital. New clinic. Lester A Thompson, MD, 1020 Lakeshore Drive, Rice Lake, Wis 54868. Phone: 715/234-9031. 4-6/80

Private practices for General Practitioners, Internists, and **OB/GYN** sponsored by teaching hospital in Illinois. Paid interviews, guaranteed income. Relocation. Special arrangement for rent and equipment. No fees. Will assist with state license. Resume-Professional Referrals, 107-14 Queens Blvd, Forest Hills, NY 11374 or call 24 hours 212/263-0400. p4/80

Physicians Exchange

continued

Multispecialty Group of 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Dermatologist
- Ophthalmologist
- Family Practitioner
- Psychiatrist

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. No personal investment. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

ENT—Orthopedic Surgeon needed for a primary care group of 10 physicians in northwestern Wisconsin. New 75-bed hospital. New clinic. Lloyd R Cotts, MD, 1020 Lakeshore Drive, Rice Lake, Wis 54868. Phone: 715/234-9031. 4-6/80

Two Family Physicians needed to staff branch clinics in two communities of 800—1300 people. Full association with 19-doctor multispecialty group, practice coverage and salary guarantees. New regional hospital serving five-county area. Residential location flexible. Outstanding family living environment. Contact: Administrator, Fort Dodge Medical Center, PC, Fort Doge, Iowa 50501. Phone: 515/573-4141. p4-5/80

Family practitioner wanted. 13-man, mixed group practice seeking family practitioner to join its Family Practice Department of six family practitioners located 100 miles south of the Twin Cities in a community of 25,000. Ideal community with excellent schools and multiple recreational opportunities, new hospital. Liberal benefits and top salary offered. This is a choice practice opportunity in rural southern Minnesota. Please contact James Burns, MD, 210 N St Mary St, Albert Lee, Minn 56007. Tel: 507/373-1441. pl-4/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Neurologist wanted—Clinical Neurologist wanted to practice in conjunction with a 6-member Internal Medicine Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 470 in care of the Journal. 9tfn/79

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN

MEDICAL PROFESSIONAL PLACEMENTS

5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency 9tfn/79

Diagnostic radiologist wanted to join two-man service corporation covering 185-bed hospital and 32-physician clinic. Consideration for early partnership. Contact Jacob M Gerend, MD, 705 Oak Tree Rd, Sheboygan, Wis 53081. Tel: 414/458-0050. 12/79, 1-5/80

The Nicolet Clinic, SC a progressive 33-physician multispecialty group is looking for physicians in the following areas of practice:

- Pediatrics
- Dermatology
- Nephrology
- Family Practice

Modern, state of the art facilities, adjacent to Theda Clark Regional Medical Center and another building located on the Fox River. First-year salary open; full membership after one year. Liberal benefits including qualified Profit-Sharing Plan, and emphasis upon continued education. Outstanding professional and personal life-style opportunities. Excellent recreational area, located on the north end of Lake Winnebago. For more information, send letter and resume in confidence to E E Wilson, MD, Chairman, Recruiting Committee, or D J Anderson, FACMGA, Admin, Nicolet Clinic, SC 411 Lincoln St, Neenah, Wis 54956, or call 414/725-7071. 12/79,1-5/80

Primary care internists and family practitioners wanted, board certified or eligible, for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel: 414/289-5910. 1-6/80

Internist wanted: Board certified or eligible to join (July 1, 1980) nine-physician, multispecialty group of four internists, two pediatricians, two ob/gyn, and general surgeon. Clinic building next to community hospital expanding service area in western Milwaukee metro fringe location; first-year salary with optional second-year corporate stockholder, excellent fringe benefits including pension and profit-sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Tel: 414/673-5745 (Collect) 1tfn/80

Fifty-physician multispecialty clinic in west-central Wisconsin wants allergist and family practitioner to do acute medicine. Also family practice openings in nearby satellite offices. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact G E Owen, MD, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5222. 2-5/80

PEDIATRICIAN—To join 5-man department in a multispecialty clinic, practicing general and consultative pediatrics. Northeastern Wisconsin community of 50,000 with referral base 100,000; excellent medical facilities; referral Intensive Care Nursery; progressive lakeside community. Contact G D Reilly, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Tel: 414/725-7071. 2-7/80

Cardiologist, Urologist, Otolaryngologist needed by 19-doctor multispecialty group in North Central Iowa. New clinic and hospital facilities. Community of 32,000, service area of 80,000. First-year salary guarantee plus incentive. All corporate fringe benefits. Excellent schools, college, and recreational activities. Contact: Administrator, Fort Dodge Medical Center, PC, Fort Dodge, Iowa 50501. Phone: 515/573-4141. p4-5/80

Neurologists: Board eligible or certified neurologists sought for practice with busy neurosurgical group. Prefer experience with EEG and EMG Excellent starting salary and fringe benefits. Contact Dept 472 in care of the Journal. 11tfn/79

Wanted: General Surgeon needed to join group of three Board Certified Family Practitioners. Present surgeon in group retiring after 24 years of excellent established practice. Cumberland is a lovely city of 2000 surrounded by lakes. Six-man clinic adjacent to remodeled 47-bed hospital and new surgical suite. Minneapolis, St. Paul, and Eau Claire each 80 miles away. Contract negotiable. Corporate member in one year. Contact D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 2-4/80

Family practice physician wanted to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Obstetrician/Gynecologists/Family Practitioners. Multispecialty group of 28 physicians is offering practice opportunity to: Obstetrician/Gynecologists to join 4-member department and Family Practitioners to join 8-member department. Attractive income offering and excellent fringe benefits; modern well-equipped clinic building and hospital medical school teaching appointment available. AAAHC accredited facility and CAP accredited laboratory. Satellite practice location also available. Excellent educational system and facilities. Recreational activities, exceptional locally, and your choice outside of area within three hours traveling. Contact J E Hartfield, MD, Medical Director, or F J Wilkus, FACMGMA, Administrator, Olmsted Medical and Surgical Group, PA, 210 9th Street, SE, Rochester, Minn 55901, or call 507/288-3443. 2-4/80

Urologist position available at progressive VA Medical Center located in Michigan's upper peninsula. Board Certified candidates are preferred. The community offers ideal family living in town of 18,000 people with good schools, year-round sportman's area with excellent hunting, fishing, and winter sports. Well equipped 214-bed GM&S medical center offering competitive salary and benefits. Applicants must meet required spoken and written English proficiency. Write: Chief-of-Staff, VA Medical Center, Iron Mountain, Mich 49802 or call: 906/774-3300, ext 227. Allowable moving expenses paid. Equal opportunity employer. 2-4/80

Family Practitioners. Rural midwestern community, population 3500 with service area of 8500, seeking two Family Practitioners. Thriving community, self-sufficient with unified community support by physicians. Thirty minutes from State Capital with readily available tertiary medical support. Interested parties should contact Dept 478 in care of the Journal. 3-4/80

Experienced General Surgeon needed to join two general internists, a gastroenterologist, three family practitioners and a pediatrician in a busy satellite of the Marshfield Clinic at Ladysmith, Wisconsin. Send curriculum vitae to Sidney E Johnson, MD, Medical Director, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449, or call collect at 715/387-5253. p4-5/80

Medical Emergency Service Associates (MESA), SC has immediate openings for qualified Emergency Physicians in a northwest area close to Chicago which is an ideal setting in a new progressive hospital. The community offers an excellent school system and many community activities. It is a short distance from all of the cultural offerings in Chicago, as well as driving distance to water sports, hunting, fishing, and many winter activities. This is a perfect opportunity for a physician and his family. MESA offers salary computed up to $84,000 annually, excellent working conditions, flexible scheduling and fringe benefits, plus the opportunity to join a stable, growing corporation dedicated to providing quality emergency medical services. Send your CV or telephone: MESA, 188 Industrial Drive, Suite 316, Elmhurst, Ill 60126; Miss Barten, telephone 312/832-4504. MESA would like to be a part of your future. 4-6/80

Surgeon-General/Vascular, noncardiac chest. Position available with a 16-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, hospital, educational, civic advantages. Please call collect or write: B J Stoehr, MD or W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Phone: 414/494-5611. 4-7/80

Ob-Gyn wanted—To practice in conjunction with a 4-member OB-GYN Dept of a 19-physician multispecialty group located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Interested parties should contact Dept 471 in care of the Journal. 9tfn/79

General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

Wanted—Family Physician to associate with four family physicians and two general surgeons to work in a satellite clinic with another family physician. 12 miles from Fond du Lac, Wisconsin, a community of 37,000 located on Lake Winnebago in the heart of Wisconsin's agricultural and recreational area. 60 miles from Milwaukee, Green Bay, Madison. Rotation of night and week-end call with four family physicians. 300-bed hospital. Excellent schools, four-year liberal arts college, two-year University of Wisconsin extension. Contact: John U Peters, MD, 505 East Division St, Fond du Lac, Wis 54935. Call collect 414/922-3700 (business) or 414/922-7899 (home). 4-7/80

Wanted: Primary Care physicians interested in full or half-time employment with the Department of Health and Social Services, Division of Health. Assisted by excellent nursing staff, these physicians will render quality health care to adults and juvenile residents of Wisconsin Correctional institutions located throughout the state. Current full-time opening at Waupun Correctional Institution and a half-time vacancy at Kettle Moraine Correctional Institution, Plymouth. Excellent salary and fringe benefits. Malpractice insurance paid. For more information, contact Barbara Whitemore, RN, 110 East Main St, Room 608, Madison, Wis 53703, or call 608/267/7170. An Equal Opportunity Employer Functioning Under an Affirmative Action Plan. 4-5/80

Physicians Exchange

continued

Emergency Physician needed June-July 1980 to replace vacancy in five physician career oriented group at Madison, Wisconsin's largest emergency service. Great place to work and live. Send CV and will call you. John P Rahm, MD, 6105 Ridgwood Ave, Madison, Wis 53716. 3tfn/80

Family practice, OB-GYN, pediatric and internal medicine positions available with a 16-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 2-5/80

Student Health Physician wanted to join two others, an internist and gynecologist, in outpatient care of 8000 college students. Residency in primary care and interest in sportsmedicine preferred. Certified lab and physical therapy unit included within facilities. Academic year appointment, no night/week-end call. MD license to practice in Wisconsin. Effective date 8/18/80. Salary dependent upon experience. Send CV and references to S M Johnson, MD, Director of Health Services, University of Wisconsin-LaCrosse, LaCrosse, Wis 54601 by May 15, 1980. Phone: 608/786-8559. EOE. 4/80

Wanted General Psychiatrist. Private practice. Northern Wisconsin community. Central Northwest Psychiatric Clinic. Contact J M Tobin, MD, 2712 Stein Blvd, Eau Claire, Wis 54701. Phone: 715/834-2751. 4-6/80

Medical Facilities

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Beautiful medical building for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

Medical suites available in new medical building. Attached parking ramp. Adjacent to major hospital. For details call 414/637-5681, Racine, Wisconsin. 1tfn/80

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Office for rent. 926 Milwaukee Ave, South Milwaukee, Wis. Any portion or entire 2nd floor available. 600 to 3600 sq ft. Will divide and remodel to suit. Immediate occupancy. Phone: 414/545-2152. 4-5/80

Medical Clinic available in small Central Wisconsin community near Wausau. Fully equipped including x-ray and lab, emergency room, etc. Enjoy the northwoods and take advantage of this ideal situation. Call Gloria Rybarczyk, 715/359-0521 or write Action Realty, 928 Grand Ave, Schofield, Wis 54476. p4/80

Real Estate

Doctor of Florida Real Estate. A retired colleague of the Society will help you in the selection of a retirement home, condominium, investment property, or tax shelter anywhere in Florida. Wilcox Gallery of Homes, Inc—Realtor: Howard V Morter, MD, Realtor-Associate, 336 Golfview Rd, North Palm Beach, Fla 33408 (residence address) 305/622-7006 home; 305/842-6131 office. p4/80

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Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

WISCONSIN—1980

MAY 2: *Working with the person using physical symptoms to control anxiety,* Mendota Mental Health Institute, Madison. Seminar presented by the Staff of the Institute's Inservice and Community Training Unit. Info: Jane Morris, Registration Coordinator, Inservice and Community Training Unit, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704.

MAY 2-3: *Vascular Surgery Symposium,* The Wisconsin Center, Madison. Fee: $145. Approved 12 credit hours in Category I for PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

MAY 2-3: Wisconsin Urological Society Annual Meeting, Edgewater Hotel, Madison.

MAY 3: *Nursing Care of Patients with a Colostomy,* St Mary's Hospital, Rhinelander, Wis. Sponsored by American Cancer Society-Oneida Unit and St Mary's Hospital, Rhinelander. No registration fee but advance registration recommended to: Eddie Klecker, RN, In-Service Director, St Mary's Hospital, 1044 Kabel Ave, Rhinelander, Wis 54501.

MAY 8: *Ninth Annual Madison General Hospital Medical Staff Spring Symposium,* Madison. Focus on health promotion and cardiac rehabilitation. Six credit hours in Category I of the AMA-PRA, and AAFP prescribed credit applied for. Further information: Medical Staff Office, Madison General Hospital, 202 South Park, Madison, Wis 53715 (phone: 608/267-6103). Program: Opening address—*Get Off Our If's, And's, or But's: Mobilizing Resources for Health Promotion,* by Donald Percy, Secretary of the Dept of Health and Social Services, State of Wisconsin, *Experience of a Family Physician in Community Preventative Medicine,* by John A McAuliffe, MD; (orientation to the newly opened MGH Center for Health Promotion); *The Use of Health Hazard Appraisal as a Health Education and Preventive Medicine Technique,* by John M Nelson, MD and Richard O Schafer, PhD; *Clinical Guidelines for Exercise Training and Cardiac Rehabilitation,* by Peter G Hanson, MD; (luncheon in the MGH cafeteria); *Diagnostic Evaluation of Patients Following Myocardial Infarction: What Should be Done for Whom?,* by W Eugene Musser, MD and George T Bandow, MD; *From Day One: Writing a Prescription for Cardiac Rehabilitation,* by W Eugene Musser, MD and Michael Giese, PhD, Exercise Physiologist; (registrants assemble in Bolz Auditorium); keynote address—*Wellness Revolution: Who Will be the Leaders?,* by William Hettler, MD, Director, University Health Center and Lifestyle Improvement Program, University of Wisconsin-Stevens Point. Partial support of the program provided by the Madison General Hospital Medical and Surgical Foundation.

MAY 8-9: *Cancer and Human Values,* Holiday Inn, LaCrosse, Wis. Sponsored by American Cancer Society-Wisconsin Division, Inc and LaCrosse Unit. Registration fee $10 payable to: American Cancer Society—Wisconsin Division, Inc, PO Box 1626, Madison, Wis 53701.

MAY 9-10: *Wisconsin Neurological Society* meeting, Concourse Hotel, Madison. Open to all interested physicians and all allied health personnel. Approved for Category I credit. Dr Raymond Chun, president, will preside over the informal, educational program Friday evening at 8:00 pm. Saturday's program starts at 9:00 am and ends at 4:30 pm with panel presentations on current neurological problems. Dr Francis M Forster, Madison, is program chairman (phone 608/262-1999).

MAY 16-17: *Neurology Update: Common neurologic problems in adults and children,* St Marys Hospital Medical Center, Madison (10 hours prescribed CME credit). Info: Charles Miley, MD, 1313 Fish Hatchery Rd, Madison, Wis 53715.

MAY 17-18: Workshop on Practice Management, Red Carpet Inn, Milwaukee. 11½ hours AAFP and AMA Category I credit. Info: AAFP, 1740 West 92nd St, Kansas City, MO 64114.

MAY 21: *Breast Cancer* seminar at Sheraton Inn, Madison. Sponsored by Wisconsin Clinical Cancer Center and University of Wisconsin Hospital Auxiliary. Info: Cancer Information Service, 1-800/362-8038.

MAY 22-23: *The family treatment,* at Marc Plaza Hotel, Milwaukee. Sponsored by Medical College of Wisconsin (11.5 hours prescribed CME credit). Info: Ross E Carter, PhD, 8701 West Watertown Plank Rd, Milwaukee, Wis 53226.

MAY 23: University of Wisconsin Medical Alumni Day, Madison.

MAY 30: *The Family in Primary Care,* Wisconsin Center, Madison. Fee: $50. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

JUNE 11-14: *Cardiac Rehabilitation: Critical Issues and Practical Concerns,* Red Carpet Inn, Milwaukee. Eligible for AMA Category I credit; UW-Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

WISCONSIN—1980

Jun 12-13: *Neurosurgical Intensive Care Symposium,* Inn On The Park, Madison. Fee: Physician, $110; Nurse, Resident, $60; Physician/Nurse Team, $140. Info: Contact Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

JUNE 13: Special workshop on *Cancer Causation: Environmental Factors,* at the Concourse Hotel in Madison, from 8:00 to 11:30 am, during the Eastern Cooperative Group Semi-annual Meeting, June 11-14. Details appear in box elsewhere in this section.

JUNE 13-14: *SMS Services, Inc* will present a seminar for doctors on reducing personal tax liability and increasing net worth, at Olympia Resort, Oconomowoc. Watch for further details in upcoming issues.

JUNE 19-20: *Symposium on the Diabetic Pregnancy and the Infant of the Diabetic Mother,* Wisconsin Center, Madison. Fee: $130. 12 credit hours of PRA-AMA Category I. AAFP prescribed credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

JUNE 23-25: Symposium on *Complications in Vascular Surgery,* cosponsored by the Division of Surgery of the Medical College of Wisconsin and the Council on Cardiovascular Surgery of the American Heart Association, at the MCW in Milwaukee.

JUNE 25-27: First Annual Madison Clinical Conference with this year's theme: *Therapeutic Advances in Infectious Disease.* Presented by Extension Services in Pharmacy in cooperation with the School of Pharmacy and the Clinical Pharmacology Section (Department of Medicine), University of Wisconsin-Madison. Conference will explore the following subject areas: (1) selected areas of infectious disease, (2) quality assurance and drug utilization review, and (3) research methods and funding sources. Program has a dual appeal to both clinical pharmacists and infectious disease physicians; attendees should benefit from the interaction provided by this interdisciplinary approach. Acceptable for 15 credit hours in Category I for the PRA-AMA. Deadline for registration is April 24. Info: Alan L Hanson, PhD, Extension Services in Pharmacy, School of Pharmacy, 425 North Charter St, Madison, Wis 53706, or call 608/262-3130.

JUNE 26-28: Wisconsin Academy of Family Physicians Annual Scientific Assembly and Congress of Delegates, Chula Vista Resort, Wisconsin Dells, Wis. Info: WAFP, 850 Elm Grove Rd, Elm Grove, Wis 53122.

JULY 20-26: *Fifth Annual Wellness Promotion Strategies,* University of Wisconsin-Stevens Point. Limited enrollment. Info: WELLNESS PROMO V, Fred Leafgren, Student Life-Delzell Hall, University of Wisconsin, Stevens Point, Wis 54481. Phone 715/346-4194 or 715/346-2611.

OCTOBER 15-17: *The Sociopath 1980: A Practical Inquiry,* symposium and workshop addressing the problems of the community, the cop, the court, the classroom, and the clinician. Sponsored by the University of Wisconsin and the Mendota Mental Health Institute. Info: Bernadine Eve Bednarz, MSW (phone 608/263-4431) or write UW-Extension, 414 Lowell Hall, 610 Langdon St, Madison, Wis 53706.

Eastern Cooperative Group
SEMI-ANNUAL MEETING

June 11-14 — Madison
Concourse Hotel

Special workshop, Friday June 13, 8:00 to 11:30 AM

CANCER CAUSATION: ENVIRONMENTAL FACTORS

Moderator: **Henry Pitot,** Director of McArdle Laboratory

Panel: **Roswell Boutwell,** Professor of Department of Oncology, University of Wisconsin; **Elizabeth C Miller,** Associate Director of McArdle Laboratory; **Elizabeth Whelan,** Executive Director, American Council of Science and Health, New York, and Research Associate at Harvard University; and **Arthur Upton,** Professor of Clinical and Environmental Medicine, New York Medical Center

(3.5 hours of Category I CME credit)

For information about the other sessions, call Barbara Miller (608/263-7837) at the ECOG Office, 905 University Ave, Madison, Wis 53705.

MINNESOTA—1980

JUNE 5-6: *Legal and Ethical Aspects of Treatment for the Critically and Terminally Ill Patient,* at Radisson South Hotel, Minneapolis, Minn. Sponsored by American Society of Law & Medicine, in cooperation with the Minnesota Hospital Association, Minnesota Medical Association, and others. For physicians, attorneys, nurses, hospital administrators, ethicists, and others. Advance registration required; $110 for members of sponsoring organizations and $130 for nonmembers. Register with: American Society of Law & Medicine, 520 Commonwealth Ave, Boston, Mass 02215.

SELECTED TOPICS IN GENERAL SURGERY—ABDOMINAL SURGERY

Sponsored by University of Wisconsin-Extension, Continuing Medical Education; University of Wisconsin-Madison, School of Medicine, Department of Surgery

September 5-6, 1980 at Wisconsin Center, Madison

The first of a planned series of annual conferences for the general surgeon. Emphasis on recent advances and controversial issues relating to the hepatobiliary system, upper and lower GI disease and management of cancer of the bowel. There will be discussion of each segment and related issues.

Fee: $115. 9 credit hours Category I of AMA. 9 University of Wisconsin-Extension CEHs.

Contact: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

JUNE 13-14: *Laboratory Diagnosis—A Comprehensive Approach to Test Ordering and Interpretation,* Marquette Inn, Minneapolis, Minn. Sponsored by Mount Sinai Hospital, 2215 Park Ave, Minneapolis, Minn 55404. Registration fee: $100. Meets criteria for 10 credit hours in Category 1 of PRA-AMA. Approved for 10 hours, AAFP. (Phone: 612/871-3700, ext 1117, Mrs Evelyn Peterson, Medical Staff Secretary).

OTHERS—1980

MAY 9-11: *American College of Nuclear Medicine* 9th annual scientific meeting, at Hyatt Regency Hotel, Montreal, Canada. Subject: *Radiation and Public Health: The Myth of Radiation—An Attempt at Clarification.* Application being made for Category 1 credits. Fee: $95. Details: J R Maxfield, MD, ACNM Secretary, PO Box 19412, Medical Center Station, Dallas, Texas 75219.

JUNE 20-22: *Second Annual Trauma Symposium,* a continuing education course for physicians, at the Dutch Inn, Lake Buena Vista, Disney World, Florida. Sponsored jointly by the Committee on Trauma of the American College of Surgeons and the Region IV Committee on Trauma, ACS. Course curriculum will include such topics as: pediatric trauma, head injuries, renal failure, spinal injuries, management of the cardiovascular system, infection in trauma, chest injuries and blunt trauma. Advance registration limited to 300. Fee $175 for physicians; $75 for nurses and residents. Contact: Richard H Clark, MD, FACS, Chairman, 415 South 28th Ave, Hattiesburg, MS 39401; or the ACS Trauma Department, ACS, 55 E Erie St, Chicago, IL 60611.

AMA—1980

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

JULY 20-24: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

American Society of Internal Medicine

MAY 15-18/WASHINGTON, DC

Ages, Wages and Ethics: An Agenda for the Eighties

What does Grey Panther leader Maggie Kuhn have to say on the problems of the aged? How about the FTC's Michael Pollard on his agency's impact on medical ethics? Or, Jerry Brazda, editor of *Washington Report on Medicine and Health,* on health legislation as we enter a new decade? These speakers and others on the program: AMA's Assistant General Counsel B J Anderson with AMA's position on the FTC and medical ethics; Yale University's George M Silver, MD, with an analysis of how internists can keep up with inflation; and Boston University Medical Center Director Richard H Egdahl, MD, PhD, with a penetrating look at the cost-effectiveness of HMOs and IPAs. Leonard D Schaeffer, administrator of DHEW's Health Care Financing Administration, will address a luncheon session of the meeting.

The meeting is open to the public and there is no registration fee. Info: ASIM, 2550 M Street NW, Suite 620, Washington, DC 20037 (Phone: 202/659-0330).

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News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

COUNCIL UPDATED ON ANTITRUST AND ORGANIZED MEDICINE ISSUE. BJ Anderson, Esq, assistant general counsel of the American Medical Association, gave a presentation on "Antitrust and Organized Medicine" to the SMS Council at its March 26 meeting in Milwaukee. Anderson reviewed the current cases in which the AMA as well as other medical organizations and the FTC are involved. She noted that the FTC order currently prohibits any physician, group of physicians, or medical association, among others, from engaging in acts which the FTC feels unlawfully restrict competition. It is the recommendation of the AMA that if any segment of organized medicine has a committee to help third-party payors determine what is a reasonable payment for a physician's service, that it stop this activity until the courts have finally ruled on the FTC order via the current AMA appeal.

In related developments . . . Congress approved a resolution in March to fund the FTC through April. While several minor amendments to the authorization bill were agreed to in a House-Senate conference, still up in the air is the important issue of what sort of legislative veto will be imposed on FTC regulations. A bill has been introduced by Sen Howard Metzenbaum (D-Ohio) which would repeal insurance companies' immunity from federal antitrust laws. Metzenbaum introduced the bill, S 2474, after a General Accounting Office report found what it felt were serious shortcomings in state regulation of insurance companies. The Senate Judiciary Antitrust and Monopoly Subcommittee will soon be reviewing the measure, but it is not anticipated that any definitive action will be taken this year.

HOUSE RECOMMENDS UNRESTRICTED FLUIDS FOR ATHLETES. The State Medical Society of Wisconsin was authorized to petition the Wisconsin Interscholastic Athletic Association to encourage all coaches to have fluid available to athletes in training and encourage its use without restriction, in a resolution adopted by the SMS House of Delegates last month. The resolution, introduced by the Lincoln County Medical Society, expressed concern with problems of dehydration and electrolyte imbalance among those who participate in competitive sports at the high school level.

AMA RECOMMENDS PHYSICIANS LIMIT 1980 FEE INCREASES TO 6-8%. The American Medical Association urges that physicians, when setting their fees during the first half of 1980, keep in mind the difference between the Consumer Price Index for all items and the Physician's Service Index of the CPI. In 1979 that gap was 3.9%—the Consumer Price Index for all items was 13.3% and the Physicians Service Index was 9.4%. Anticipating a 10% to 11% inflation rate in 1980, the AMA recommends that fee increases in 1980 range from 6% to 8%. The AMA says it will reassess this target in mid-1980.

CARTER RECOMMENDS BUDGET CUTS FOR HEALTH AND HUMAN SERVICES. The Dept of Health and Human Services budget will face cuts of more than $370 million for fiscal 1981 and $220 million for fiscal 1980 in recommendations sent to Congress by President Carter last month. Carter trimmed the $1.4 billion budget request for health services by $117 million. The Center for Disease Control request for $3.6 billion would be cut by $97.6 million. The National Institutes of Health would lose $91 million, and the Health Resources Administration would lose $73 million. Mental health program cuts amount to $12 million, drug abuse $36 million, alcohol abuse, $51 million. A supplemental request for fiscal 1980 for the National Health Service Corps was reduced in the budget rewrite to $1.1 million. The President requested an increase of $127.9 million for the Medicaid program funding under the Health Care Financing Administration. ■

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WISCONSIN MEDICAL JOURNAL

MAY 1980

• Pay dues on time • *In perspective:* A prospectus for '81 • Inpatient treatment program for chronic pain • Museum of Medical Progress reopens May 1-October 31 • *Annual Meeting:* President and President-elect's messages to House of Delegates, elections of House and Council, summary report of House of Delegates

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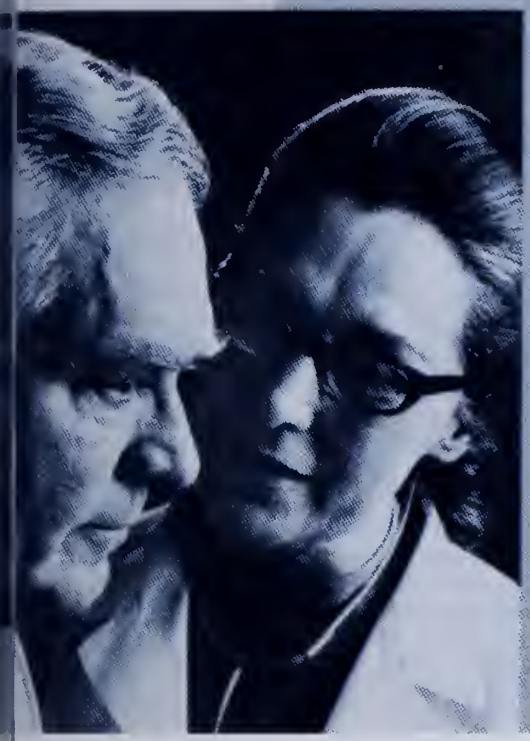

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CONSENT FORMS FOR PHYSICIANS

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701; or tel. 608/257-6781. (Member physicians in Wisconsin may dial toll-free number: 1-800-362-9080.) Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms. These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
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Form 18: Artificial insemination homologous consent.
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Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
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Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
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Form 40: Consent to disposal of amputated part of organ.
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Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

Editorials

Editorial Director: WAYNE J BOULANGER, MD

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Pay dues on time

AN ORGANIZATION such as our state medical society receives the major part of its annual income early in the year when most of the members pay their dues. During those early months when the coffers are full, funds which are not needed until later can be put to work drawing interest through short-term investments. With interest rates as high as they are these days, this can amount to a significant amount of money which can be used to help keep dues down and the budget in balance.

As of March 7, 1980, there were 750 members who had paid nothing toward their 1980 dues. If they had paid in full by the January 1 due date and that money had been invested at 15% through the end of March, $9700 interest would have been realized.

Holding off dues payment until the last minute may be good business for the individual, but in the long run it penaiizes the entire society and is unfair to those who pay on time.—WJB

Jellied brains

JOHN D MACDONALD is the author of the Travis McGee series of best selling novels. He writes of motorcyclists: "Hundreds of them roar up and down the highway in formation, making formal protest about the law forcing them to wear a helmet. It is a violation of their freedom and liberty, they say. Very macho. But when they don't wear helmets, they abuse the taxpayers, taking a couple of weeks to die in intensive care, their primitive brains jellied by hard impact with the concrete highway. Somebody has to pick them up when they go down and deliver them to Emergency, regrettably."

The National Highway Traffic Safety Administration now reports that fatalities from motorcycle accidents have increased 46 percent since 1976, the year individual states began repealing mandatory helmet laws. This despite only a one percent increase in new motorcycle registrations in the same period.

The safety administration warns that motorcyclists triple their chances of being killed by failing to wear helmets and that thousands of needless deaths and disabling head injuries have resulted because of the repeal of helmet laws.

In view of these figures, one wonders if the helmet protestors or those who ride bare-headed might not have jellied cerebra prior to the hard impact with the highway.—VSF

Decertification guidelines

PRESENTLY there are discussions underway regarding the decertification guidelines for cardiac catheterization laboratories and cardiac surgery by the Bureau of Needs Review which is a part of the State of Wisconsin's Department of Health and Social Services.

The problems these people are addressing *(ie,* mortality, morbidity, assessment of quality, numbers of procedures for competency) in the field of cardiac catheterization and cardiac surgery require the wisdom of Solomon. Unfortunately, that gentleman no longer occupies this planet in viable form. History has indicated that governmental agencies seldom if ever approach the intellectual norm of our society in their power of reasoning and judgment.

The nuances regarding the quality of cardiac surgery require a profound in-depth knowledge of cardiology and cardiac surgery, to say nothing of cardiac physiology, anatomy, and so forth, which is not possesed by lay people. For instance, any accurate assessment of mortality requires an in-depth analysis of the preoperative cardiovascular status and will, of necessity, minimally include abnormal and normal coronary artery anatomy, ventricular ejection fraction, status of the pulmonary competence, and the like. More importantly, the cardiac surgeons involved will have difficulty agreeing on many facets of this particular project because of individual prejudices and attitudinal sets.

It is ludicrous to suggest that such proposed guidelines now under consideration will increase the quality or the availability of such care.

While not in complete agreement with Nobel laureate Milton Friedman's economic concepts, it would perhaps be better to allow the consumer in the marketplace to decide which programs will flourish and which will fail. Although certainly imperfect, such an approach would seem much preferable to extensive mindless regulation by a governmental agency.—RDS ■

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

CME in the community hospital

DOCTOR Pohlmann's article (WMJ, February 1980) on continuing medical education in the community hospital is a good re-statement of the hopes of the CME legislation. Like most articles on the subject, however, it provides no insight as to how the needs of the medical staff can be identified realistically. Moreover, and more importantly, it sheds no light on how we can measure how well or whether the educatory efforts have succeeded in accomplishing their goals.

One hopes that the roseate expressions in the summary are correct—but, as far as I know, there appears to be no documented proof that (1) CME programs—either nationally or locally have significantly altered physician behavior or practice and (2) that CME programs are cost effective. Surely, the statement that CME programs "have become the most effective as well as unifying pathway in the control of quality and cost of health care" must be an expression of hope, charity and faith. One gets the uneasy feeling that this may be another example of "cognitive dissonance." Most studies suggest that one of the major contributing factors to missed or delayed diagnoses may be sensory overload of the physicians rather than knowledge deficiencies. If that were the case, educational efforts, although desirable, would not be expected to be critical.

It would appear that we would all be better served if future articles on the subject could supply us with good hard data—just the facts, ma'am (or sir).

—C H Altshuler, MD
Milwaukee, Wisconsin

Federal Employees Program

IN THE MARCH 1980 issue of the *Wisconsin Medical Journal* Dr Nicholas L Owen indicates that the major difference between the Federal Employee Health Insurance Program and other insurance programs "is nonpayment of hospital benefits when the services performed could reasonably have been done on an outpatient basis or at a lower level of care (nursing home, etc)." Astonishingly, RDS in an editorial comment disagrees with this logical approach toward health care cost reduction without decreasing quality of health services and sees health insurance plan patients as "second class patients." In the opinion of myself and the Cost Containment Committee of the Brown County Medical Society, *all* insurance plans should exclude payment of hospital benefits when "the services performed could reasonably have been done on an outpatient basis or at a lower level of care."

The Cost Containment Committee of the Brown County Medical Society under the leadership of Dr Jeremy Green (Chairman) has compiled a list of 65 suggestions designed to contain health care costs without sacrificing quality. The following of the 65 suggestions provide direct support for the policies of the Federal Employee Health Insurance Program and, in addition, are recommendations to be applied to all patients regardless of the nature of the policies of the patients' third-party payer.

9. Aggressively seek alternatives to hospitalization—home health care, extended care, nursing home.
10. Avoid hospitalization for observation, overnight rest, diagnostic studies. Decrease incentives for hospitalization.
13. Reduce postoperative stay in hospital—encourage earlier home and office follow-up visits.
21. Encourage and utilize one-day-care units. Consider "morning-of-surgery" admissions.
22. Have hospital social service evaluate patient who will probably need extended care shortly after admission rather than at the end of their stay.
54. Educate patients in health care cost—dispel the attitude that most expensive is the best.
55. Explain that hospitalization is the largest component of health care cost. Discourage hospitalization whenever possible.

Numerous surveys indicate that health care costs are viewed by the public as the major prob-

lem facing the medical profession. We in the profession have an opportunity to be a positive influence in solving this problem.

—Herbert F Sandmire, MD
Chairman, SMS Commission
on Public Information
Green Bay, Wisconsin

. . .

I RECEIVED a copy of Doctor Sandmire's letter regarding the editorial "Federal Employees Program." I believe my comments were misinterpreted. I strongly support reduction of healthcare costs if there is no reduction in quality.

My objection to Doctor Owen's suggestions centered about the identification and labeling of the patient's records for members of the FEP. It would seem to guarantee that these patients are treated differently. I would have absolutely no objection if a physician treated all of his patients in the fashion outlined by Doctor Owen. If this were true, of course, then there would be no need to identify FEP patients. I still feel, as outlined by Doctor Owen, those enrolled in the FEP become second class patients. I still disagree with the author and the editorial.

With the covenant that patients are not identified as to whether they are covered by third-party payers, Doctor Sandmire and I are in complete agreement.

—Richard D Sautter, MD
Marshfield, Wisconsin

. . .

Editor's Note: A complete list of all 65 recommendations, referred to above, that physicians can use to cut healthcare costs in their communities is available from the Cost Containment Committee of the Brown County Medical Society (Jeremy R Green, MD, Chairman, 900 South Webster Ave, Green Bay, Wis 54301; phone: 414/437-0431) who encourages other Wisconsin physicians to take the initiative and implement them in their respective communities.—VSF

Alzheimer's disease

I WOULD like to make a comment in regards to the value of the CT scan in the diagnosis of senile dementia and Alzheimer's disease *(WMJ,* November 1979).

I would like to support Doctor Green's position *(WMJ,* March 1980) that CT scan is of very limited value in making that diagnosis, although it may be of value in eliminating other diagnoses; *ie,* tumor, subdural hematoma, etc, which may have a presentation similar to that of senile dementia. I would like to draw the attention of your readers to a paper presented by Doctor Gado, Chief Neuroradiology section, The Edward Mallinckrodt Institute of Radiology and Professor of Radiology of Western University School of Medicine, Saint Louis, Missouri at the International Symposium and Course on Computed Tomography held at Miami Beach, Florida March 19-24, 1978.

This involved a prospective multi-discipline random study of individuals at 65 years of age or more coming to CT scanning for various reasons.

After a general medical and neurological evaluation, the mental status of each subject was investigated, particularly with emphasis on long and short term memory, judgment, and orientation. Based on this together with historical information, each subject was given a global rating of 0 (no dementia) or 1, 2, 3 (mild, moderate, or severe dementia). Criteria for those scores were developed by the Dementia Study Group of Washington University. The CT scans were then analyzed regarding the presence of ventricular dilatation, the size of the cerebral sulci and the presence of white matter lucencies. In this study, it was concluded that an increase in the size of the ventricles and subarachnoid space occur as age progresses and the presence or absence of dementia in the old does not influence the size of the ventricles or subarachnoid space. In this study, the increase in the volume of the CSF space, both ventricular and subarachnoid, was almost the same for patients with or without dementia. This is also supported by pathological studies as well.

In my view, the reliance on the CT scan to diagnose "dementia" is almost nonsensical as this is a clinical diagnosis. The CT scan is useful only in excluding other causes for dementia.

—Y H Gabriel, MD
Wausau, Wisconsin

. . .

Editor's note: This subject has now been covered sufficiently in the last few issues of the WMJ. Any further correspondence can be directed to the individual physicians concerned.—VSF

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In Perspective

COMMENTARY ON LEGISLATIVE/SOCIO-ECONOMIC ISSUES IN MEDICINE

A prospectus for '81

Brian H Jensen, Madison, Wisconsin
Director, SMS Physicians Alliance Division

Political ability is the ability to foretell what is going to happen tomorrow, next week, next month and next year. And to have ability afterward to explain why it didn't happen.

—WINSTON CHURCHILL

A TELEVISION commercial for a savings and loan here in Madison begins with a silent visual review of a rural landscape decorated with a soft snowfall. This peaceful scene describes the Wisconsin winter as a time for reflection and rest accompanied by a review of the summer harvest. Of course, it quietly but quickly evolves into an implied need for the services of the financial institution in planning and saving for the future and the upcoming harvest—something the S & L feels it can offer its potential customer notwithstanding the economic conditions facing the country.

Unfortunately, the time for rest and reflection on legislative and political harvests never quite seems to be available. To be sure, the first 24 hours after the adjournment of the Wisconsin Legislature on April 3 did offer some time for those of us who follow and work with the Legislature to look back upon the last 18 months with a sense of satisfaction. The '79-80 Legislature presented itself as only the second full session since the implementation of the revitalized approach by organized medicine in this state to impact upon that process. Both sessions have been successful and have resulted in consideration of issues that have had major effects on physicians:

- Certificate-of-need
- Student loan program changes
- Significant adjustments, both financially and procedurally to the medical assistance program
- Major health insurance proposals, including minimum benefit standards, insurance for "uninsurables," and others
- Substantial alterations in the professional liability arena both in statutory and administrative law
- Reasonable changes in the status of other health providers including nurse-midwives, physicians' assistants, and others.

Needless to say, the list could go on for pages and the items listed above are just examples of the issues faced by physicians over the past two sessions. A most obvious question in this discussion is: Why has organized medicine been able to effect changes in the manner it has, and how can these two sessions be characterized as "successful?"

I have personally heard physicians cite the Physicians Alliance as the reason for the upswing in the legislative and political fortunes of organized medicine in Wisconsin. While it is always reassuring to receive such an endorsement, the real reason is the physicians themselves. Six years ago, as an employee of the Legislature, I witnessed the efforts of physicians from the other side of the fence and saw disorganization. That is no longer a fact of life for physicians because of their own initiative: the thousands of hours spent at the local level meeting with legislators, the hundreds and hundreds of letters and telephone calls to legislators summarizing positions and concerns, and the thousands of physician-hours spent in 1976 and 1978 in legislative candidate interviews. Those efforts have been sophisticated, well-thought-out and planned and executed with a "facts-oriented" base.

For that, *you* are to be commended.

As the 1981 session of the Legislature approaches, the next harvest session needs to be planned. One of the characteristics of the legislative process that prohibits much time for rest and reflection is that it is a methodical, incremental system that does not cease with the temporary recess for campaigns. The candidate interviews which will be conducted by Wisconsin physicians will have a direct bearing on the standing physicians will have in 1981 and beyond. But what of the issues?

Political forecasting is a dangerous exercise. It is dangerous because when errors are made, the assumption is that the prognosticator was ill-prepared or without "political ability." However, since the late 1960s, the game has changed so dramatically that no one is immune from error. Even state legislative issues are volatile and

unpredictable. In spite of that risk, 1981 seems to be looming on the horizon with the following concerns for physicians:

1. Reimbursement for physicians in the Wisconsin Medical Assistance Program. The Joint Finance Committee has directed DHSS to review physician reimbursement in Medicaid and prepare options for the future. When, why, or how these changes will occur, if any, are unclear at this point. The involvement of organized medicine in this area will depend greatly upon the proposals put forth by the agency.
2. Professional liability issues have surfaced periodically in the last session, but several key initiations from the Physicians Alliance Commission are likely in 1981; they include the organization of the WHCLIP Board of Governors and its relationship to the Patients Compensation Fund, use of the informal panels, the procedural rights of a physician in a settlement, and a reduction in panel fee assessments.
3. The traditional confrontations over the scope of practice of non-physicians in the "health care" delivery system are likely to surface again. These issues will revolve around the basic question of "who can provide what" in that system and the standing of such persons in the health insurance arena. The 1979 session witnessed the rejection of at least two attempts to mandate non-physicians into the health insurance policies sold in Wisconsin. Hopefully that trend will continue as more and more legislators become aware of the costs of requiring insurance policies to provide mandated services.
4. Health planning will also be reconsidered by the Legislature via proposed administrative rules to finalize implementation of the certificate-of-need/decertification law passed in 1977, and efforts in the Legislature by SMS to eliminate objectionable features of both programs.
5. Mental health laws and the provision of mental health services in Medicaid will also be a priority in medicine's attempt to recodify elements of Chapter 51 of the statutes and to eliminate distinctions between physicians in the delivery of psychotherapy under Medicaid.
6. Finally, a host of other bills will undoubtedly be reintroduced as the 1981 Legislature again considers brain death, laboratory certification, and the licensing and examining board structures in the state.

The list is by no means inclusive. While Governor Dreyfus and others have called for less legislation and less government intervention, the trend towards "political medicine" shows no sign of subsiding. Many issues in 1981 will be familiar and predictable and others will be new.

As predictable as the Legislature may be at times, so should the response of physicians. The last four years have shown the value of active, local involvement in the process and its issues. To do otherwise is dangerous indeed.

Over the next few months, physicians and members of the Auxiliary will be asked to participate in candidate interviews, planning for 1981, and local Physicians Alliance committee work when the session begins. In your hands will rest the final success or failure of those missions. ■

CORRECTION: In an attempt to subscribe to the words of "Sir Winston," last month's *In Perspective* stated that 1979 AB 699 failed to pass in the waning hours of the session. The bill *did* pass, and T-19 now covers burial expenses for T-19 recipients. It was signed into law by Governor Dreyfus as Chapter 206 on April 24, 1980.

BHJ

Bookshelf

New books received *are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.*

Executive Health: How to Recognize Health Danger Signals and Manage Stress Successfully. By Philip Goldberg. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1978. Pp 288. Price: $4.95.

Aborting America. By Bernard N Nathanson, MD. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 336. Price: $10.00.

Vitamin C Against Cancer. By H L Newbold, MD. Stein & Day, Publishers, Scarborough House, Briarcliff Manor, New York, NY 10510. 1979. Pp 320. Price: $10.95.

Stopping Wife Abuse. By Jennifer Baker Fleming. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 532. Price: $8.95.

Getting What You Deserve, a Handbook for the Assertive Consumer. By Nancy Kramer and Stephen Newman. Doubleday & Company, Inc. 245 Park Ave. New York, NY 10017. Pp 352. Price: $8.95.

The Ms. Guide to a Woman's Health. By Cynthia W Cooke, MD and Susan Dworkin. Doubleday and Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 456. Price: $14.95.

Treating Your Hyperactive & Learning Disabled Child—What You Can Do. By the New York Institute For Child Development with Richard J Walsh. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 168. Price: $8.95. ■

Special

The birth throes of the Wisconsin Medical Practice Act: The physicians versus the newspaper editors

John T Cirn, PhD, Iowa City, Iowa

Conflict between the mass media and physicians over a variety of issues has long been a familiar story. What may not be so well known is that one of the major obstacles to the passage of strong state medical practice acts at the turn of the century was *newspaper editors.* The interests of state medical societies in laws aimed at elevating the standards of medical practice clashed with the financial interests of the press in uninhibited rights to advertise. In 1905, organized medicine in Wisconsin found itself battling the state press association over the powers of the Medical Examining Board, and a lobbying victory by the editors resulted in a statutory provision that severely crippled the Board for the first 70 years of its existence. This was the provision vesting the power to revoke medical licenses not with the Board but with the courts.

As the law continued to hold until a major reform in 1976, the Medical Examining Board or *any* individual or group could only make a recommendation for a license revocation or bring a complaint against a license-holder to certain legal officers, generally the district attorney of the county in which the alleged misconduct took place. The public official then had the responsibility for commencing and prosecuting a civil action in a circuit court against the license-holder.

By the mid-1970s, Wisconsin was the only state in the nation whose medical and dental licensing authorities did not possess the statutory power to take away licenses once granted. Moreover, in Wisconsin, those two boards were the only ones among all the occupational licensing boards which did not have the power to revoke the licenses they granted. Here is the story of the political origins of that weakness.

Prelude: The Reign of Laissez-faire

In the mid-nineteenth century, as the nation was expanding westward, there were virtually no laws regulating the practice of medicine in any of the states. Anyone was allowed to practice any profession or engage in any business as the spirit of *laissez-faire* prevailed, as the tenet of freedom of contract held sway.[1]

In Wisconsin, an 1849 statute vested the duties of examining medical students and granting diplomas with the censors of the county and state medical societies. The State Medical Society established requirements for membership that included the passing of medical examinations. In 1881, the State Legislature enacted a law restricting the use of the title "doctor" to individuals who held a diploma from an incorporated medical society or college or who was a member of the State Medical Society or a county society legally organized in the state. It was not until 1897 that the State Medical Society succeeded in getting the Legislature to enact the state's first Medical Practice Act and establish a State Board of Medical Examiners. This occurred nine years after the US Supreme Court upheld another state's medical practice act as a valid exercise of the police powers of the state.[2] In what was typical practice among states, the Wisconsin act allowed applicants for a license the alternative of taking an exam or simply presenting a diploma from a medical college.

It was not until 1905 that the power was established to revoke a license, for fraudulently procuring a license or for "immoral or unprofessional conduct."

Bills Are Introduced

The act authorizing medical license revocations was the product of a battle in the closing days of the

This article is an extract from Mr Cirn's doctoral dissertation, *The Political Life of Organized Medicine in Wisconsin* (The University of Wisconsin-Madison, 1978). Doctor Cirn is an Assistant Professor, Graduate Program in Hospital and Health Administration, College of Medicine and Graduate College, University of Iowa, Iowa City, Iowa. Reprint requests to: John T Cirn, PhD, Graduate Program in Hospital and Health Administration, University of Iowa, S517 Westlawn Bldg, Iowa City, Iowa 52242. (Phone: 319/356-2593) Copyright 1980 by the State Medical Society of Wisconsin.

1905 legislative session which was marked by bitter interest-group fighting.[3] Organized medicine was the force behind a bill which it viewed as professional self-regulation necessary for the protection of consumers. The antagonists were the state's newspaper editors. The newsmen posed medicine's demands as self-serving denial of freedom of the press and as violation of the sacred property rights of citizens.

The bill in question was drafted by attorneys for the State Medical Society of Wisconsin and the Medical Society of Milwaukee County and was introduced by a physician-assemblyman who chaired the committee which reported the bill for passage. A physician-legislator introduced a duplicate in the Senate. The bill called for empowering the State Board of Medical Examiners to deprive physicians of their license to practice when found by the board to be guilty of "immoral or unprofessional conduct." Such conduct was quaintly defined—and continued to be so defined until 1976—as, among other things, advertising in any newspaper

> . . . the curing of venereal diseases, the restoration of lost manhood, the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse, or excessive indulgence, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whereby the monthly periods of women can be regulated . . .[4]

Also considered as unprofessional conduct was the obtaining of any fee on the "promise that a manifestly incurable disease can be or will be permanently cured."

The Editors Object

The press fiercely opposed this bill with almost absolute unanimity, just as it had opposed an anti-patent-medicine bill which was killed by the state Senate shortly before. One editor wrote that non-advertising doctors "were going to crucify liberty on the cross of professional envy and greed by putting the 2,500 physicians of Wisconsin under a government by an executive bureau."[5] The *Milwaukee Journal* attacked the bill as giving a segment of the profession "complete power over the professional fate of any practitioner," as solely calculated to restrict competition and raise prices, as a "blow aimed at the fundamental rights of citizens," and as assuming that consumers are "too imbecile to care for themselves."[6] The *LaCrosse Chronicle* wrote:

> By the terms of this bill every doctor in the state is constituted a possible assistant editor to all the papers in his community. The assistant editor-doctor may read the advertising columns for the announcements of his professional competitors and then get them driven out of the state by preferring charges before the medical board.[7]

The bill originally introduced provided for license revocation without appeal by any other agency. After editors appeared before the legislative committees, the bill was modified to allow doctors who had their licenses revoked to appeal to a court for reinstatement. The Assembly then gave the bill preliminary passage by a vote of 58 to 29.

That night, Milwaukee newspaper editors "united in a midnight Macedonian cry by wire" and called on their fellow editors throughout Wisconsin to wire legislators to oppose the "anti-advertising bill." Three hundred telegrams were received within a single day. The next morning the Assembly voted by 60 to 39 to reconsider the bill and send it to the Judiciary Committee which was then, as it is now, composed almost exclusively of lawyers.

The Board is Weakened

Editors and spokesmen for the state press association denounced the bill again before this committee, one editor pointing out that "only" six other states had seen fit to pass such a law. The hearing was marked by attacks and defenses of large medical advertisers in the state. A divided committee reported the bill back to the Assembly after making further concessions to the anti-medical forces, such as a provision that an appeal to the courts could stay any license revocation order by the State Medical Examining Board.

For the next week the press throughout the state published editorial condemnations of the bill. After vigorous floor debate, the Assembly passed the bill by a vote of 64 to 24 that crossed party lines. A substitute bill was killed which would have made it necessary for the board to appeal to a court and submit the evidence on which a complaint was based to a judge for judicial determination. Those who held out for vesting of the power in the courts contended that it was unwise to permit the same official body to act at the same time in the capacity of prosecutor, judge, and jury.

On the Senate side of the Capitol, the State Affairs Committee held "long and heated sessions" on the proposal. It finally divided equally, reporting the bill without a recommendation to its parent body. Consideration of the measure was laid over by the full Senate, and in the interim, physicians and newspapermen lobbied. The physicians apparently conceded that prospects for passage of the bill as approved by the Assembly were hopeless. A substitute was prepared which vested the revocation power in the courts and provided that the district attorney in the county in which the complaint is made shall be the prosecuting officer. The Senate State Affairs Committee hastily called a meeting and unanimously agreed that the substitute be offered as a committee amendment. The Senate passed this bill

by unanimous consent. It was then passed by the Assembly and signed into law.

For its first 80 years, then, the Wisconsin Medical Examining Board was allowed by law to apply only the most limited and inadequate sanctions to physicians found incompetent or errant. The Medical Examining Board had only the options of warning or reprimanding a physician, or suspending his license for no more than two consecutive 90-day periods, after which the physician may have resumed practicing as he chose. In efforts to revoke licenses via the courts, the Medical Examining Board repeatedly made complaints about the difficulty of successful prosecutions, the frequency of delay, and the frustrations of legal entanglements. It would ask the state legislators to encourage district attorneys to be more zealous in enforcing the Medical Practice Act. The Board had often accepted voluntary surrenders of licenses (four in 1972, for example) as a result of its investigations, and it had relied on the threat of revocation action to persuade aberrant physicians to change their ways. But from 1954 to 1974, the Medical Examining Board had not asked a district attorney's office to initiate revocation proceedings more than five times.

A Reform is Passed

In 1976, glaring weaknesses of the Medical Practice Act were remedied when a massive revision was passed by the state legislature and signed into law. The drafting of the bill was the work largely of the chairman of the Medical Examining Board acting in collaboration with a number of professional associations, including the State Medical Society, and the reform had the strong support of the State Medical Society. The revision gave the Medical Examining Board directly the necessary authority to revoke a license for cause, along with a number of other significant powers to stop unprofessional conduct. The revision also empowers the Board (upon its finding an individual guilty after holding a formal fact-finding hearing) to suspend a license, or to limit a physician's scope of practice, for up to five years.[7]

The Legislature's deliberations over the 1976 reform bill were not lacking in vigorous political conflicts, but an entirely different array of antagonists came to the fore. Several drafts of the bill were necessitated by the pressures of podiatrists and physical therapists, who are licensed by the Medical Examining Board and covered by the Medical Practice Act, to improve the definition of their authority and responsibility. The State Medical Society acted energetically but unsuccessfully to oppose the efforts by chiropractors and optometrists to eliminate the old statutory prohibition against their using the title "doctor." Additional scrambling by lobbyists for the occupational associations in the final hectic moments of the 1976 legislative session occurred, with unclear results, over language in the bill that would have allowed all health practitioners licensed by the state to "treat the sick;" this prerogative was limited under the old law to physicians and osteopaths only. But absent in 1976 were any expressions of economic interest by the state's newspaper editors.

REFERENCES

1. See Lawrence Friedman, "Freedom of Contract and Occupational Licensing, 1890-1910: A Legal and Social Study," *California Law Review*, 53 (1965), 735.
2. The decision was *Dent v. West Virginia*, 129 U.S. 114 (1888).
3. *Madison Democrat*, June 1, 1905.
4. Section 448.18(1) (b), Wis. Stats.
5. *St. Paul Dispatch*, May 15, 1905.
6. *Milwaukee Journal*, May, 1905, *passim*.
7. To alleviate the problem of judicial delays in enforcement of the Board's penalties, the statute now allows the Medical Examining Board to "summarily" suspend a license for 30 days pending a hearing, or a designated officer of the Board may so suspend a license for up to 72 hours, if the Board has evidence establishing probable cause that such action is necessary "to protect the public health, safety, or welfare." Penalties for violation of the Act were stiffened to include fines as high as $10,000 (whereas the ceiling on fines had been only $500) or imprisonment or both. ■

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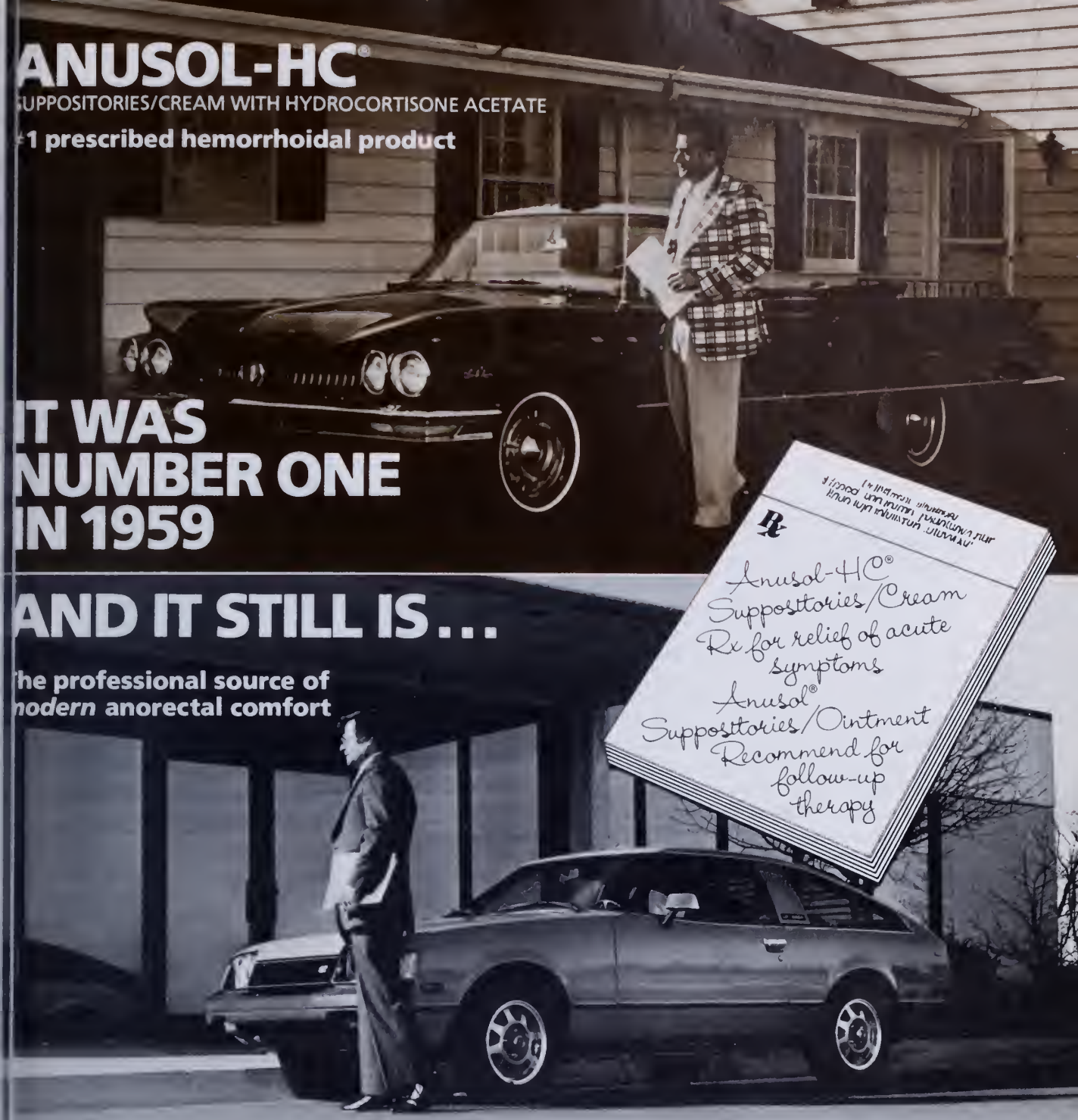

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History

Sutureless bowel anastomosis —an historical perspective

Ian D Fraser, MB, FRCS (Eng) and **Robert E Condon, MD, FACS**
Milwaukee, Wisconsin

In this era when technology is having such a profound effect on patient care, new surgical tools are accepted readily into our armamentarium. Some will stand the test of time, others will be modified or discarded as experience dictates. It is still too early to predict the eventual role of the end-to-end bowel anastomosis stapling device, but those who have had an opportunity to use this new instrument cannot fail to have been impressed. Correctly employed, it offers the potential of a secure bowel anastomosis in difficult situations such as low anterior resection. Far from being a new concept, this device embodies surgical principles gained from such of our predecessors as Travers,[1] Lembert,[2] and Halsted.[3] The device, itself, may be seen as a logical further development of Murphy's anastomosis button.

Early intestinal anastomosis technic employed inadequate suturing methods and relied on the "magical" properties of the great omentum and parietal peritoneum to achieve healing. It was the observations of Travers[1] (1812), the suture technic of Lembert[2] (1826), and the experiments of Halsted[4] (1887) that placed operative construction of a reliable intestinal anastomosis on a firm footing. Benjamin Travers, while working at St Thomas's Hospital, London, noted at autopsy that the intestine of a sailor injured by a bayonet shortly before his death, 'was so firmly united as for some time to resist a considerable distending force" produced by filling the bowel with water. Larger wounds that produced eversion of mucosa, however, did not seal. Travers concluded that "every wound is followed by inflammation . . . terminating in the union by adhesion. The union of divided bowel requires the contact of the cut extremities in their entire circumference."

Figure 1 —*Dr John B Murphy.*

Antoine Lembert (1826) extended the observations of Travers to devise an experimental method of reliable anastomotic suture. Lembert used many more interrupted sutures than customarily were employed at that time, together with firm approximation of the entire bowel circumference by inversion of the intestinal margin and serosa. Lembert did his experiments in dogs. It was Dieffenbach[5] (1836), treating a case of intestinal strangulation, who first used Lembert's method to anastomose the bowel in man.

Halsted[3,4] (1887, 1891) added the final essential observation regarding modern intestinal suture technic by first demonstrating the importance of inclusion of the submucosa in the sutures of a bowel anastomosis. But, even with the availability nearly a century ago of suture technics which were technically reliable, bowel anastomoses in situations such as

From the Vince Lombardi Colon Clinic, The Medical College of Wisconsin, and the Surgical and Research Services, Wood VA Medical Center, Milwaukee, Wisconsin. Mr Fraser is the Vince Lombardi Cancer Fellow. Portions of this work are to be submitted by Mr Fraser in a Master of Surgery thesis to the University of London. Publication support provided. Reprint requests to: Robert E Condon, MD, Vince Lombardi Colon Clinic, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. (Phone: 414/257-5506) Copyright 1980 by the State Medical Society of Wisconsin.

low anterior resection continued to be associated with appreciable morbidity and some mortality risk.

John B Murphy (Fig 1) played an important role in the history of intestinal surgery. Described as a "striking personality" by Frank Billings[6] (1904) and a "stormy petrel" by Loyal Davis[7] (1938), Murphy was one of the leading surgical figures of his day. He originally developed the anastomosis button (Fig 2) as a means to join the gallbladder to the small bowel in cases of obstructive choledocholithiasis (1892).[8] The "male" and "female" parts of the button were placed within the lumena of the two viscera to be joined. A purse-string suture brought the full thickness of each viscus onto a central hollow cylinder. When the two parts were joined, the outer flanges of the button approximated the entire circumference of the serosa. While satisfying all of the criteria elaborated by Lembert and Halsted, anastomosis was accomplished without sutures.

Murphy quickly realized the potential for the button. After animal experimentation, he suggested its use in gastroenteric and entero-enteric anastomoses, a recommendation which was internationally accepted. A recent application of the principles underlying Murphy's button is that of esophageal transection for bleeding varices which utilizes a similar device to restore gastrointestinal continuity (Boerema,[9] 1970). Functionally, the end-to-end anastomosis stapling instrument (Fig 3) is a natural further progression of the Murphy button; it involves the same requirements to purse-string bowel onto a central core to produce an inverted anastomosis.

Murphy's button went out of surgical fashion primarily due to popularization of exteriorization-resection procedures and, subsequently, the advent of "aseptic" closed anastomosis technic. Although this latter method had been introduced by Parlavecchio[10] (1897), it became popular because of the clear description subsequently published by Parker and Kerr[11] (1908). Anesthesia methods also had improved sufficiently by the early years of this century so that more attention could be paid during an operation to technical construction of the anastomosis. A sutured anastomosis then became the standard of surgical practice for the next half century.

During the past two decades, a number of stapling devices have been introduced into clinical surgical practice. In the hands of some surgeons, stapled anastomoses have largely replaced hand-sutured anastomoses. While a stapled anastomosis may represent a convenience for the experienced surgeon, the use of stapling devices by young residents probably should be interdicted until these surgeons-in-training have become proficient with the traditional suture technics that are the hallmark of the true surgeon. But, in the performance of a low rectal anastomosis, the end-to-end anastomotic stapler appears to represent a real advance for both master and novice surgeon.

The rectal suture line following low anterior resection is recognized as an area with a potential for

Figure 2 — *The Murphy button.*

Figure 3 — *The end-to-end anastomosis stapler.*

anastomotic dehiscence. Goligher[12] (1970) determined the leakage rate to be 69 percent. Symptomatic and serious complications were much less frequent, but dehiscence unquestionably added directly to the reported 2.7 percent mortality risk. While awaiting confirmation of recently reported favorable results associated with use of the end-to-end anastomotic stapler (Goligher,[13] 1979), we should not lose sight of the historic antecedents of this device. Its real conception was not on a modern drawing board, but in the work of Murphy, Halsted and Lembert. As Cromar[14] (1968) has noted, "There could be no more inaccurate impression than to imagine that the triumphs and technical excellence of modern surgery are the outcome of the work of the contemporary generation, or to believe that they would have been possible without the labors of our predecessors."

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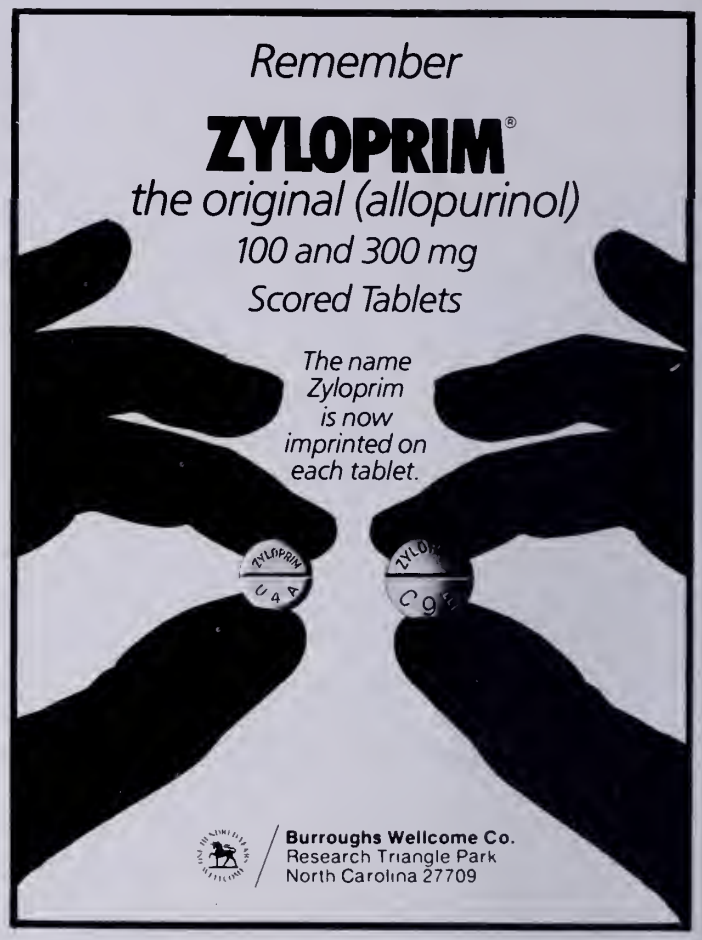

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Scientific Medicine

REFER TO—Inpatient treatment program for chronic pain. *Wisconsin Med J* 79:23-26 (May) 1980

KEY WORDS—Chronic pain, pain clinics, rehabilitation

Inpatient treatment program for chronic pain

Richard C Timming, MD; Jay J Cayner, MSW; James F Malec, PhD; Richard F Harvey, MD; Richard S Schwettmann, MD and **Julius Chosey, MD,** Madison, Wisconsin

Pain is an experience common to most of us. Acute pain serves a useful purpose as an early warning of disease or injury. Fortunately acute pain is usually short-lived, and after a period of rest and healing the body returns to its usual state of health.

For an unfortunate group acute pain does not resolve with conservative treatment, but instead it becomes a chronic pain. The person with chronic pain does not respond to the usual conservative treatment and can present a tremendous and not always appreciated challenge to our healthcare system. The financial cost of chronic pain in this country has been estimated at nearly $50 billion dollars per year reflecting medical costs, compensation, lost wages, and the like.[1] Human suffering puts this problem beyond an economic consideration.

Over recent years the medical community has placed considerable emphasis on methods to deal with the problem of chronic pain. Multidisciplinary clinics, based after the model established by Bonica, are now found in many of the major medical centers.[2]

Some patients continue to have chronic pain despite the efforts of the medical community. They do not respond to conservative treatment and often seek attention from many different physicians who try many different treatments and fail. Surgery often compounds the problem instead of helping, and medication dependency and abuse is common. Often they are not working; that is, unemployed; but also not "working" well in the family setting to the extent that relationships may very well be stressed. Chronic pain may be the major complaint, but the problem is more complex—compounded by compensation factors and family difficulties. Psychological and environmental factors cloud the original pathology causing the pain. Because of the complexity of this "chronic pain syndrome," the need for inpatient pain programs has been recognized and several various programs are outlined in the literature.[3,4,5,7]

The following is a report of the first two years' results of the Rehabilitation Medicine program for the management of chronic benign pain.

SUBJECTS. Between October 1976 and January 1979, 40 patients graduated from our Pain Management Program. Many of these patients were first screened in an outpatient multidisciplinary pain clinic, where a diagnosis of the patient's pain problem was made and an appropriate outpatient treatment program prescribed. Patients who did not respond satisfactorily to an outpatient treatment program were admitted to our inpatient Rehabilitation Medicine Pain Management Program. Withdrawal of narcotic medications is difficult to achieve as an outpatient and is another reason for admission to the Pain Management Program.

From the Departments of Rehabilitation Medicine and Anesthesiology (Pain Clinic), University of Wisconsin Hospital and Clinics, Madison, Wisconsin. Publication support provided. Reprint requests to: Dept of Rehabilitation Medicine. UW Hospital & Clinics, 600 Highland Ave, Madison, Wis 53792. (Phone: 608/263-8640) Copyright 1980 by the State Medical Society of Wisconsin.

ADMISSION CRITERIA. Admission criteria to the Pain Management Program include the following:

1. Chronic pain of six months or longer.
2. Benign pain with no malignant disease or rapidly progressive, deforming arthropathies.
3. All appropriate pain treatments unsuccessful.
4. Observable pain behavior often thought to be in excess of organic pathology.
5. No major psychiatric disturbances.
6. Usually a spouse or significant other person to help continue the program when the patient is discharged to home.

PATIENT CHARACTERISTICS. The overall average age of the patients involved in this study was 45.7 years; there were 22 men and 18 women. Location of the pain was most often in the low back region with other areas being the head and neck, hip, knee, and ankle. Several had diffuse, almost total body pain. All patients had an organic basis for their pain. Accidents were, by far, the most common original cause of the pain.

Chronic pain patients are often large consumers of healthcare systems. Our patients have had pain for an average of 6.4 years, consulted 5.7 different medical specialists (neurologists, physiatrists, orthopedists, and the like), and undergone an average of 1.8 surgical procedures for pain. Over the 12 months prior to admission, our average patient had made 17 physician visits, was hospitalized 1.6 times, and filled 21.7 prescriptions, all for pain. These patients are truly hard-core consumers of expensive and apparently unsuccessful medical care.

Medication, no doubt, is one of the most popular medical treatments for chronic pain. A majority of our patients was taking narcotic medications (73%), while use of muscle relaxants, tranquilizers, nonnarcotic analgesics, and mood elevators was common.

METHOD. Patients with chronic pain qualifying for inpatient hospitalization are admitted to our Rehabilitation Medicine inpatient service. The program is divided into several parts.

1. *Baseline*—The baseline period usually lasts one week. Patients undergo a complete medical examination and any necessary diagnostic tests or consultations are obtained. Any reasonable treatment not previously attempted may be tried. A few of our patients have had excellent relief of pain from a transcutaneous nerve stimulator or analgesic injection in combination with the physical restoration and brief psychological-social treatment program such that they were discharged at that point from the hospital.

   During the baseline week, each patient is evaluated by a multidisciplinary team consisting of rehabilitation nursing, physical therapy, occupational therapy, recreational therapy, psychology, pharmacy, vocational-educational, social service, an anesthesiologist pain specialist, and a physician specialist in rehabilitation medicine. Most of these patients are very inactive and considerably out of shape considering their age. Motor weakness is determined and a specific baseline exercise tolerance established. Exercises are determined on an individual basis to fit each person's specific needs. These exercises focus on muscle strengthening, endurance building, balance, coordination, increasing flexibility, postural training, and preventive techniques. Medication is given as necessary. Various pain behaviors, verbal and nonverbal, as described by Fordyce and Sternbach, are determined.[3,6,8]

2. *Evaluation Conference*—At the end of the baseline week, a multidisciplinary evaluation meeting is held. If it is felt the patient may benefit from a pain management program, specific goals to be achieved are determined and discussed with the patient. A contract between patient and staff is signed, listing the goals and purposes of the program. Goals usually include:

   a. Reduction in nonessential pain-related medications.
   b. Reduction in pain behaviors, such as requests for medication, talking about pain, moaning, grimacing, and the like.
   c. Increase in well behavior specifically exercise level, physical condition, leisure activities.
   d. Return to level of activity consistent with age and sex which may include educational and vocational goals.
   e. More appropriate use of the healthcare system.

   It is carefully pointed out that the program probably will not cure the pain, but rather that an emphasis is on learning to live a satisfactory life with the pain.

3. *Pain Management Program*—The Pain Management Program consists of three specific components and usually lasts another four to six weeks.

   a. ACTIVITY. Patients spend one to two hours daily in a formal exercise therapy program for the upper and lower extremities and trunk muscles. Exercises are started at a low repetition rate, determined during the baseline, and gradually increased. Daily progress can be easily followed by graphs, kept by each patient. Most patients also are placed on a progressive walking program or bicycle ergometer program. Recreational therapy programs to help the patient develop better leisure time activities are an important part of the program. Vocational-

educational components are important to help to return the patient to gainful employment, or a more useful life.

b. WITHDRAWAL OF NONESSENTIAL PAIN MEDICATIONS. Pain medications including narcotics, nonnarcotic analgesics, antidepressants, muscle relaxants, tranquilizers, and sleeping medications are given on a time-contingent basis, in cherry syrup. The dosage and time schedules are determined during the baseline period. This dose is decreased by 25 percent each week, such that at the end of four weeks, the cherry syrup pain cocktail contains no medication. Of course, the patients are informed of this method before starting the program and are told when the syrup no longer contains medication.

c. BEHAVIOR SELF-MANAGEMENT. The behavior modification aspect of the Pain Management Program is probably best conceived as an opportunity for patients to learn more productively to regulate their behavior and affective arousal despite a subjective sense of pain. The program is not a strict "operant conditioning" approach in which punishers and reinforcers are carefully identified and meticulously administered contingent upon the occurrence of well-defined target behaviors. Rather, classes of unconstructive "pain behaviors" (*ie,* inactivity, complaining) and more rewarding "well behaviors" (*ie,* exercising, hobbies, progressive relaxation, mutual social exchanges) are identified with the patient. Patients are encouraged to increase "well behaviors" and decrease "pain behaviors" through participation in a group experience led by the social worker. In a group patients have an opportunity to learn relaxation techniques, re-analyze conceptions of and beliefs about their pain and their current lifestyles, rehearse more constructive beliefs and behaviors, and receive feedback from group members and leaders. Such training in behavioral self-management of pain is similar to that described by Meichenbaum and Turk and in the manual, "Coping with Pain: A Self-Management Approach," which has been utilized by a number of patients in the Pain Program.[9,10]

Staff support the patients in their efforts toward increasing self-management by rewarding "well behaviors" with praise and social reinforcement and by ignoring (not rewarding) "pain behaviors." In cases where psychological dysfunction appears particularly severe (but not so extreme as to warrant primary psychological/psychiatric treatment), the patient is involved in individual behavior therapy as well.

Enhanced behavioral self-control is significant only if the patients can continue to effectively manage their behavior in the community after discharge. To increase the likelihood of such carryover, family or significant others are involved in the patient's program as much as possible.

RESULTS

Activity. At the time of discharge, all 40 of the patients completing the Pain Management Program were more active than on admission. "Peak" repetitions of exercises were usually at least twice the baseline amounts. Walking tolerance was usually increased as well. A vigorous recreational therapy program encouraged the development of hobbies and interests to carry back into the community. Some patients participated in an occupational, prevocational, assessment program and in volunteer activities.

Medication. As previously mentioned, the majority of our patients was taking a variety of pain-related medications at the time of admission. Narcotic analgesics were the most common medication in our sample with 73 percent of our patients taking some type of narcotic medication. Percodan® and codeine were the most frequent narcotics used. At the time of discharge, all 40 of the patients finishing the Pain Management Program had been completely tapered off all of these pain medications, including narcotics, nonnarcotics, analgesics, muscle relaxants, and tranquilizers. One patient was discharged taking an antidepressant. Although mild complaints of temporary anxiety and tremulousness during drug withdrawal were occasionally heard, there were no significant drug withdrawal problems, and most of our patients expressed a great deal of pride in having "kicked the drug habit." Those taking heavy amounts of drugs often expressed that they felt subjectively better in a general physical and psychological sense, especially mentioning their minds were "clearer."

Behavioral Self-Management. The Minnesota Multiphasic Personality Inventory (MMPI), a questionnaire measure of disturbed personality functioning, was completed by a small proportion of patients (n=16) both before and after participation in the Pain Management Program. Inspection of these patients' MMPI profiles obtained prior to entering the program revealed one normal personality profile and three groups of abnormal MMPI profiles. Group 1 (2 males, 3 females) had highest evaluations on MMPI subscales 1 (hypochondriasis) and 3 (hysteria). This type of profile is typical of the patient who tends to focus on somatic problems, possibly exaggerating physical difficulties, while ignoring or minimizing psychological or interpersonal sources of distress. Group 2 (4 males, 1 female) had a highest

elevation on scale 2 (depression) suggesting that feelings of worthlessness, hopelessness, and affective distress were of foremost concern to these individuals. Other MMPI scale elevations in this group suggest that somatic focusing, feelings of resentment, and tendencies to worry contributed in some cases to depression. Group 3 (3 males, 2 females) had the highest elevation on scale 1 (hypochondriasis) with secondary elevations on various other scales, including scales 2 (depression), 3 (hysteria), 4 (psychopathic deviate), 7 (psychaesthenia), and 8 (schizophrenia). While Group 1 appeared most focused on somatic problems and Group 2 on affective distress, Group 3 appeared concerned with both physiological and psychological sources of personal discomfort.

T-tests for correlated samples were performed on the differences between pre- and post-MMPI profiles. Group 1 showed a number of statistically significant ($p > .05$) scale score changes (higher L, K, 9; lower 1, 2, 3, 7) suggesting increased personal enthusiasm, optimism (in some cases to the point of overoptimism, "wearing rose-colored glasses," and failing to recognize personal liabilities) and diminished somatic focusing, depression, and anxiety. The other two groups showed few significant MMPI changes. Group 2 decreased scale 6 (paranoia) only. Group 3 decreased scale 2 (depression) only. No other statistically significant changes were observed for Groups 2 and 3. While the small sample sizes make any inferences based on these results extremely tentative, findings suggest that the Pain Management Program was most effective in decreasing personal discomfort and somatic focusing in patients who tend to minimize the personal significance of affective distress.

DISCUSSION

Management of chronic pain is a major healthcare problem. Very few "chronic" pain patients are ever "cured," most having to learn to manage with their pain. Patients not responding to outpatient treatment or those taking narcotic medications may benefit from a multidisciplinary pain management program.

A successful pain management program should stress making a proper diagnosis and instigating the most effective treatment.[11] Most of the chronic pain patients admitted to our program have been inactive, lack proper extremity/spine flexibility, and have poor endurance such that in most instances the correct exercise program is, in itself, therapeutic.

Chronic pain patients often have many learned behaviors that may be detrimental to their returning to a more active and productive lifestyle.[6] Being disabled can be rewarding to a person unhappily employed or having to deal with stressful relationships. Psychological-social counseling to help the chronic pain patient focus on healthy behavior is crucial. Helping a person to learn to rely on self-control techniques to conquer anxiety, depression, and pain, rather than a medication is a major accomplishment. It is interesting to note that all patients left our hospital no longer on pain medication.

This Pain Management Program was intended as a pilot project. The results mentioned above indicate a degree of success but many questions are left unanswered. The physical, psychological, and psychophysiological indicators of pain need more detailed documentation as do more specific treatment programs. Cost effectiveness of an inpatient program needs to be considered. Long-term followup of several years' duration will be necessary to judge the final effectiveness of the Pain Management Program. A research program is presently being carried out in our facility to try to answer some of these questions. Given the complexity of treating chronic pain, we certainly agree with Dr Rene Cailliet, that more emphasis should be placed on the proper diagnosis and treatment of acute pain to prevent chronic pain.[12]

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REFER TO—The premature infant: a child at risk for developmental disability. *Wisconsin Med J* 79:27-28 (May) 1980

KEY WORDS—Prematurity, neonatal intensive care, developmental disability

The premature infant: a child at risk for developmental disability

Suzanne Toce, MD, Madison, Wisconsin

EDITORIAL NOTE: Although prematurity continues to be the leading cause of neonatal death, survival continues to improve as a result of new developments in intensive neonatal care. Thus, the quality of survival is an important issue. The accompanying article provides an optimistic view.

One of the questions most commonly asked by parents is whether their prematurely born baby will be "normal."

As medicine has changed, so has the survival and quality of survival of prematurely born infants.[1] Before the 1940s, only the healthy babies survived, but their outcomes were good. From the 1940s to the 1960s, with the advent of newer technology, the mortality rate decreased. Unfortunately, the incidence of long-term sequelae was high and, in part, related to iatrogenic causes. With the introduction of "modern" neonatal intensive care in the 1960s, there was a decrease in mortality rate and improvement in the quality of survival. The perinatal approach of the last decade has continued this trend. The outcome of the small premature baby depends in part upon the medical technology and level of care available at the time of birth. The frequency and type of disability will vary depending upon when and where the baby is born.

The types of disability seen in survivors of a neonatal intensive care unit are manifold. They include a broad spectrum of intellectual, psychological/behavioral, sensory, motor, and social problems. There are many high-risk factors that put the infant at increased risk for future developmental problems (Table 1). It should be emphasized that many children with developmental disability have no identifiable problems in the newborn period; however, certain observations made in the nursery will alert us to possible future problems (Table 2).

Prematurity and intrauterine growth retardation are predictors of cerebral palsy (CP).[2] However, the absolute risk of disability is not extremely high. The majority of children with CP are of normal weight and gestation.[3] In addition to prematurity, there are several other strong predictors of CP (Table 3).

In one study, for the 0.5% of the population who were abnormal in the newborn nursery, almost 16% developed CP.[2] This is a 99-fold increase in risk compared with the general population. It is important to have continued follow-up. Of children with CP, 43% were felt to be normal in the newborn period.[2] As many as 17% of children with CP were

Table 1—High-risk factors for neurologic sequelae

Risk factors identified at the time of birth:
Prematurity
Intrauterine growth retardation
Asphyxia
Multiple gestation
Congenital infection
Congenital anomalies
Syndromes secondary to maternal drug ingestion [alcohol, diphenylhydantoin (Dilantin®), etc]

Postnatal risk factors:
Respiratory distress syndrome
Intracranial hemorrhage
Neonatal seizures
Meningitis
Apnea
Jaundice
Metabolic abnormalities (acidosis, hypoglycemia)
Malnutrition

Table 2—Observations in the newborn nursery

Feeding problems
Temperature instability
Poor cry
Abnormal tone
Abnormal moro reflex
Abnormal neurologic examination at time of discharge

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Table 3—Neonatal risk factors for CP (listed in terms of increasing risk)[2]

Temperature instability
Abnormal tone
Birth weight < 2000 g
5 minute APGAR < 3
Poor activity or cry beyond day one
Need for gavage feedings
Head circumference > 3 standard deviations from the norm
Multiple apneic episodes
10 minute APGAR < 3
Neonatal seizures
Impression of abnormal brain function

normal in the first year of life,[4] and as many as 12-40% of children that had findings suggestive of CP in the first year of life were normal at one year of age.[2,4]

Despite these problems, the outlook for small premature infants is surprisingly good. Of low-birth weight (< 1500 g) babies cared for at the University Hospitals of Cleveland in 1975 and 1976, about 80% of survivors were normal at a mean of two years of follow-up.[1] Those babies with asphyxia, intracranial hemorrhage, severe respiratory failure, or extreme intrauterine growth retardation represented the majority of the babies who did poorly.

In summary, prematurity rarely exists without associated factors that put the infant at increased risk for neurologic sequelae. Most of the very low-birth weight babies do well. But, despite the fact that the majority of children with developmental disabilities are term infants, premature infants continue to be disproportionately represented. Thus efforts should be directed towards avoiding prematurity. Alert prenatal care will detect correctable causes of prematurity such as incompetent cervix and will allow for early diagnosis of premature labor so that the chances for successful treatment are enhanced. Prenatal risk assessment for prematurity should be part of the evaluation made at each prenatal visit.

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Abstracts

Hyperimmunoglobulin E snydrome: response to transfer factor and ascorbic acid therapy

WILLIAM R FRIEDENBERG, MD; JAMES J MARX JR, PhD; RAYMOND L HANSEN, MD; and RAY C HASELBY, MD, Depts of Hematology, Allergy, and Infectious Medicine, Marshfield Clinic, and the Marshfield Medical Foundation, Inc, Marshfield, Wis: *Clin Immunol Immunopath* 12:132-142, 1979

This report presents the case history of a 29-year-old man with hyperimmunoglobulin E syndrome and the successful treatment with transfer factor and ascorbic acid. The patient presented with a marked defect in the ability of his lymphocytes to respond to mitogens, in skin test response to DNCB challenge and other recall antigens, and a variety of *in vitro* granulocyte function defects. The presence of a serum inhibitor to lymphocyte and granulocyte function was found. This individual had multiple episodes of mucocutaneous candidiasis and staphylococcal infections. Clinical improvement was evident after transfer factor and ascorbic acid treatment. Many of the *in vitro* functions also returned to normal. ■

Surveillance of antibiotic use in a community hospital

ROCCO LATORRACA, MD and RONALD MARTINS, MD, Dept of Laboratory Medicine, Trinity Memorial Hospital, Cudahy, Wis: *JAMA* 242:2585-2587 (Dec 7) 1979

An ongoing system of antibiotic surveillance was initiated in a community hospital. The system was based on the guideline audits of antimicrobial use published by the Veterans Administration Ad Hoc Interdisciplinary Advisory Committee on Antimicrobial Drug Usage. The surveillance is accepted well by the medical staff. It has proved to be cost-effective and educational. A changing pattern of antimicrobial drug use has been recognized that has resulted in decreased antimicrobial drug costs. ■

Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER
IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN
AND ITS HEALTH SERVICES DIVISION

Bladder cancer etiology and natural carcinogens[1]

Natural factors which cause bladder cancer are expressed primarily in areas where there has been little industrialization.

Schistosomiasis was the first natural factor to be associated with bladder cancer. During infection with *Schistosoma haematobium* or *Bilharzia haematobium,* female worms often deposit eggs in capillaries of the bladder causing irritation. This disease is a problem in Egypt and areas of Africa where the organism is endemic due to poor sanitation and the presence of a species of snail that is an obligatory intermediate host for the parasite. Nitrosoamines may be produced *in situ* in the bladder. Tryptophan metabolism is abnormal in about half the patients.

The major carcinogenic components of cigarette smoke, polycyclic aromatic hydrocarbons, and arylamines are ubiquitous pollutants of air, soil, and water. There is a dose-response relationship between smoking and the relative risk of bladder cancer for both men and women. Small amounts of 2-naphthylamine can be detected in urine of smokers and may be the responsible carcinogen. In Boston it is believed that about 35-40% of bladder cancers are due to cigarette smoking; this percentage may be higher in Canada.

Several primary aromatic amine metabolites, structurally similar to known occupational amine bladder carcinogens, are derived from the essential amino acid L-tryptophan and present in human urine. There may be a relationship between excretion of these metabolites and spontaneous development of bladder cancer, according to Dr Raymond R Brown of the Wisconsin Clinical Cancer Center. The substances are present in all normal human urines and excreted in elevated amounts by about half of bladder cancer patients. Patients who excrete excessive amounts develop more heterotopic bladder tumors. However multiple factors may be operating in the etiology, as some patients have normal tryptophan metabolism. Abnormal levels of urinary tryptophan metabolites are more frequent in patients from Wisconsin than in those from Boston. Supplemental pyridoxine (vitamin B_6) reduces the amount of metabolites excreted and decreases the recurrence rate of bladder cancer. Metabolism of L-tryptophan is dependent on the bioavailability of vitamin B_6, so there may be a relationship between bladder cancer and deficiencies of this vitamin.

One of the most interesting collaborative efforts has been with Doctors A M Pamukcu and E Erturk of Turkey. Doctor Pamukcu became interested in bladder cancer when it was discovered that 25-30% of all cattle in a northern area of Turkey suffered from this neoplasm. Studies showed that bracken fern *(Pteris aquilina),* a forage contaminant, was responsible. It also causes bladder tumors in sheep, water buffalo, rats, guinea pigs, and mice; intestinal tumors in rats and Japanese quail; and lung and lymphoid cancers in mice. Concern has been expressed for people, since the fern is consumed in Japan, New

Doctor Bryan

[1]Second of a series on studies being done on bladder cancer at the Wisconsin Clinical Cancer Center in Madison under the leadership of Dr George T Bryan.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or the State Medical Society of Wisconsin, Health Services Division, PO Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

Zealand, Canada, and the United States. Indirect exposure of humans in Turkey, Yugoslavia, and Bulgaria is also possible, since the bracken fern carcinogen, excreted in the milk of cows pastured on fern, can cause intestinal and bladder cancers in rats fed the milk.

Tumor incidence is as high as 90% in adult cows depending on geographic area. Factors which influence the pattern, location, and incidence of neoplastic lesions induced by bracken fern are: age of the animals, duration of ingestion; thiamine, nitrate, nitrite, or bicarbonate supplementations; and induced microsomal activity by chronic phenothiazine administration. Induction of microsomal enzyme activity after prolonged administration of phenothiazine as indicated by increased activity of benzo (a) pyrene hydroxylase in the small intestines, liver, and kidneys was associated with fewer intestinal and urinary bladder neoplasms in fern-fed rats. The fern contains active mutagens and carcinogens. Quercetin, isolated from the fern, has recently demonstrated both properties. Metabolism of fern by the animal or by flora in the gastrointestinal tract may be necessary for complete expression of carcinogenic activity and production of tumors.

The information obtained from these studies may help clarify the etiology of human bladder cancer, since similar compounds may be present in other plants and vegetables consumed by man that are carcinogenic for the urinary bladder and alimentary tract.

One of the important outgrowths of this work has been the development of rodent animal vesical cancer models that are replicative of human disease. These models will enable scientists to study the carcinogenic activity of various substances in animals, identify possible environmental bladder carcinogens, and hopefully develop better ways to diagnose and treat human bladder cancer.

In a future Cancer Column the early detection and diagnosis of bladder cancer will be discussed.

—Dorothy J Buchanan-Davidson, PhD
Science Writer, WCCC ■

Abstracts

Biologic markers in breast carcinoma. IV. Serum fucose-protein ratio. Comparison with carcinoembryonic antigen and human chorionic gonodotrophin.

T PHILLIP WAALKES, PhD, MD; CHARLES W GEHRKE, PhD; DOUGLAS C TORMEY, PhD, MD;* KWANG B WOO, PhD; KENNETH C KUO, MS; JACK SNYDER, MD: and HANS HANSEN, PhD (*Wisconsin Clinical Cancer Center, Madison, Wis): *Cancer* 41:1871-1882 (May) 1978

Elevated levels of serum protein-bound carbohydrates occur in patients with active metabolic diseases, acute illnesses, and neoplastic diseases (primarily disseminated disease). The serum fucose/protein (SF/P) ratio was evaluated as a potential biologic marker for patients with metastatic breast cancer. When blood samples from 150 patients were analyzed for SF/P, carcinoembryonic antigen (CEA), and human chorionic gonodotrophin (hCG), 95% had one or more of the three markers increased, 85% had an above normal SF/P, 75% above normal CEA, and 40% above normal hCG. SF/P was exclusively increased in 12%, CEA in 4%, and hCG in 2%. Both SF/P and CEA were elevated in 39%; SF/P and hCG in 6.0%; hCG and CEA in 4.7%; and all three in 27.5%. In general multiple measurements provided a higher detection sensitivity for patients with metastatic disease. When individual patients who had objective evidence of progressing disease were followed, the values for SF/P, CEA, and hCG increased as the amount of tumor burden became greater. Patients with high CEA values also had elevated SF/P values, which suggested a coincident rise with increasing tumor burden. Patients with the highest levels of hCG frequently had increased SF/P and CEA values. All patients with above normal SF/P and CEA values showed a decreased value during response to chemotherapy; hCG did not appear to correlate as well to response or progression of disease. Changes in SF/P may represent a nonspecific response to disease. Changes in the level of serum protein-bound carbohydrates, such as SF/P, may be useful for following patients during the course of their disease, especially when combined with the measurement of other selected markers.

—Dorothy J Buchanan-Davidson, PhD
Science Writer
Wisconsin Clinical Cancer Center ■

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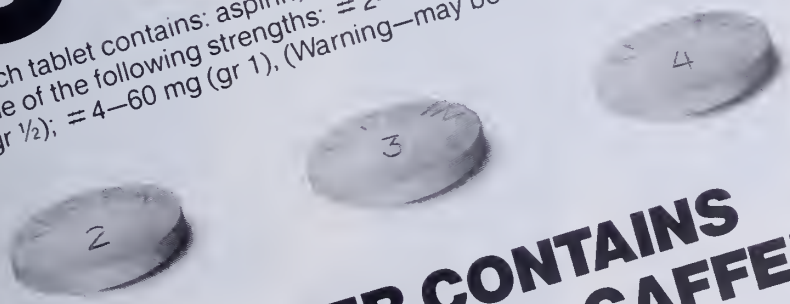

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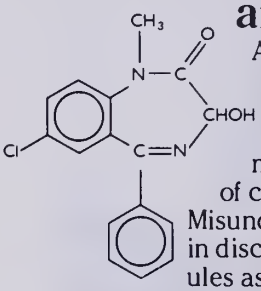
Aspects of Management

What to tell your patients when you prescribe Valium® (diazepam/Roche

Survey shows significant correlation between comprehension and compliance



A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.* Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy. Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

What Valium (diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms. Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.

What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, *et al*: *Am J Hosp Pharm 31*: 485-491, May 1974

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, Stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics,

Practical pointers on taking antianxiety medications

do's Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects. Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

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es, MAO
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action. Usual precautions indicated in patients
erely depressed, or with latent depression, or with
cidal tendencies. Observe usual precautions in impaired renal or hepatic function
nt dosage to smallest effective amount in elderly and debilitated to preclude ataxia or
rsedation

e Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea,
gue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache,
ontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention,
rred vision. Paradoxical reactions such as acute hyperexcited states, anxiety,
lucinations, increased muscle spasticity, insomnia, rage, sleep disturbances,
nulation have been reported, should these occur, discontinue drug. Isolated reports
eutropenia, jaundice, periodic blood counts and liver function tests advisable
ring long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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The oath of office: President Lewis and Council Vice-chairman Timothy Flaherty, MD

President Lewis . . .

Report to the House of Delegates as President-elect

My theme today is:

"Practice the best damn medicine you can, and everything else will take care of itself"

One of the things I had not counted on when you honored me by electing me to the post of President-Elect last year was that I would be following a professional speaker, Darold Treffert. We have been very fortunate in having a man of his ability in all areas as President. He will be a hard act to follow, and an impossible one for me as a speaker. Many of his best thoughtout and worthwhile proposals have appeared in the *Wisconsin Medical Journal* under the President's Page column. I hope all of you have had the opportunity to read them.

When Darold came to the Wood County Medical Society last year to speak, the title of his presentation was "Fast Horses, Old Whiskey, Young Women, and More Money." In trying to follow the precedent of having a theme, which doesn't necessarily have to be followed, my theme today is: "Practice the best damn medicine you can, and everything else will take care of itself."

That was the philosophy of the medical profession when I began practice. It has been hotly debated, at least in our organization at home, for many years. It is my contention that unfortunately the medical profession has paid perhaps too much attention to that philosophy as we have dealt with the public, and as a result, we have neglected keeping up with the times. Society changes and we have to adjust to those changes. In general, society is going to get from people, and even professions, what society feels it wants. The United States has changed from an agricultural society in the 1800s to an industrial society in the early 1900s and now, as I heard last month in Chicago at the AMA Leadership Conference, to an informational society, with 54% of employed individuals working in that arena. The philosophy that "big is better" is rapidly disappearing in this country. People are disillusioned with political parties, and they are disillusioned with the presidency, feeling that it doesn't make much difference who is elected. The trend now is away from centralized control to local control. Almost every state now has its legislature meeting every year and has established a four-year term for the governor. In addition to the trend toward decentralization, a single issue such as gun control, abortion, and the like has become much more important than overall general philosophy. We must adapt to this changing situation.

Since 1980 represents the beginning of a decade, it might be expected that we should talk today about the challenges of the 80s. A recent poll taken by the AMA shows that physicians today consider cost of medical care, government regulations, and maldistribution of physicians as the three major problems facing us. It is interesting that malpractice no longer appears in the top three. At the same time, polls taken of the American public show that they consider the cost problem as No. 1, but they also consider as No. 2 the quality of care which they receive. The State Medical Society already has committees and

Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, March 27-29, 1980, in Milwaukee.

commissions working on all of these problems. However, we need all of the input we can get from you, the physicians of the state, to help meet the challenges in those problem areas. It might be helpful in encouraging you to do that if I review how your State Medical Society functions.

The House of Delegates is the ultimate authority of the State Medical Society. Many times in small discussions, Secretary Earl Thayer or one of his staff will tell us, "well, this is the Society's position because the House of Delegates adopted that policy at a meeting in 1974," or some other year; and believe me, I have discovered that if the House adopts a policy, it remains the policy of the Society until it is changed by this House. For that reason it is important that when you, as leaders, make policy at these annual meetings, you are knowledgable about the issues. Hopefully you all realize the great opportunities you have to bring policy problems to this body through yourself or your county medical society by presenting resolutions. The Council, which meets seven times a year and acts as an interim governing body, also forwards to this House of Delegates those questions which require major policy action.

From time to time you see or hear in the media that the State Medical Society has taken a certain policy. These, if they have not already been established by the House of Delegates or the Council, usually refer to a position taken by one of the commissions of this Society. The Governmental Affairs Commission or the Health Planning Commission are just two groups that have been extremely active in recent years in reviewing activities that are going on, making comments, and frequently establishing the position of the Society. I mention these two specifically out of the nine or ten commissions, only because they are more visible in response to legislative activities at the State Capitol. As I have seen them function, I have realized that this is one of the least understood and appreciated areas of Society activities. The physicians involved devote a great deal of time, effort, and thought before they act.

From time to time decisions have to be made in a hurry, particularly when the Legislature is in session. As President-Elect, I find that about once a week I get a telephone call from Earl Thayer saying that he has been discussing with the President of the Society, the Chairman or Vice-chairman of the Council, perhaps the Speaker of the House, or the Chairman of certain commissions that may be involved, as to what position the Society should take. The State Medical Society is not one in which the staff makes the decisions. It has been extremely encouraging to me to learn first-hand how the SMS functions. I believe that Earl Thayer and his staff are a fine group of men and women whom we are fortunate to have working with us. They are dedicated to the concept that the Society should be run by, and reflect the thinking of, the physicians.

In addressing the problems listed by the AMA as identified by physicians, we heard yesterday at the Council the report of the Ad Hoc Committee on Distribution of Physicians. That will be updated and completed by May; we periodically receive reports from the Cost Containment Committee. The Physicians Alliance Commission has been the arm of the Society dealing with the government and the regulations that continue to bombard us in a somewhat different fashion than the Governmental Affairs Commission. Government regulation will not go away. If the sociologists are correct, more of these regulations can be expected to come from state government in the future, but again the Alliance is providing good leadership in this direction and has been one of the most positive programs of the SMS in recent years.

To solve our problems, given the newly emerging type of society, it is important that we work with the people who are involved in all areas that impact on the health care of the public. Our need is to have input in the decisions that will be affecting this care. At the AMA Leadership Conference in Chicago we were told that California was sort of a bellwether state, and as California went in social trends, the country usually followed. At the present time it takes six people to change a light bulb in California, one to do the work and five more to share the experience. People want, and expect, to be involved today. We must work with them rather than react to them.

A new problem I see is the possible changing role of the physician. During the recent statewide study on the nursing program, I talked to many nurses and asked them to define what a nurse is today. Nurses seem to have much confusion in trying to decide where nursing is going. Recently one of them asked me, "what is the role of the doctor today?" Medicine, too, is changing. By and large, we are no longer the unquestioned captain of the ship. Today young men and women in training are learning to work under the team concept. I expect it is here to stay for at least this generation. Hopefully physicians may continue as captain of the team, but it will have to be through leadership, rather than just by decree.

You are all familiar with the wellness movement that is going on in this country, and also the single issue groups that have sprung up to handle problems related to medicine and wellness. Such organizations involved in breast feeding, natural childbirth, ostomy care, mended hearts; way of life, coping, smoking problems, and the like, are becoming commonplace in every community. Each disease seems to have a lay group involved, and in many instances their philosophies and approach are somewhat different than the medical profession. In addition to those lay groups, we are encountering the expanding role of the nurse practitioner, physician assistant, pharmacist, psychologist, social worker, physical therapist, and the like. We as a profession must

learn how to relate better to these groups, whether they be the professionals or the interested lay people, so that we may maximize our ability to deliver quality health care. This means perhaps that we will have to take another look at the role of the physician in today's society, and I feel that the Council must do that in this coming year.

The cost of care is important, regulations are important, distribution of physicians is important, but most important is practicing the best damn medicine we can, because without it we can accomplish nothing. Medicine cannot stand alone, just as physicians can no longer stand alone. Our Medical Society must continue to strive for maintaining and upgrading quality, but this requires in today's society being conscious of, and working with, these changing attitudes.

Working with government, allied health professions, and the public are necessary today. If we do that, we will be able to achieve the objective which the State Medical Society has outlined in the purpose of the new Constitution, Article II: "The purpose of the Society is to bring together the physicians of Wisconsin to advance the science and the art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." We can control our own destiny if we can continue to work together and work with society which is becoming much more knowledgable and interested in the problems of their health care. ■

DRUG NOTE

Tagamet® (cimetidine)

SmithKline Corporation announced April 24 that the US Food and Drug Administration had approved the use of Tagamet® (cimetidine) to prevent the recurrence of duodenal ulcer.

Tagamet® has been marketed in the United States for the treatment of the acute stage of duodenal ulcer disease since 1977. Worldwide, the drug has been used by approximately 15 million patients since 1976 for both the treatment and prevention of ulcers.

Approval for longer term use of Tagamet® in the United States follows FDA review of data submitted to the agency in 1979 that involved treatment with the drug for periods of up to one year. The data demonstrated that Tagamet® significantly decreased duodenal ulcer recurrence from more than 50 percent per year to approximately 15 percent.

The maintenance dosage—two tablets of 200 mg at bedtime—is indicated for duodenal ulcer patients "likely to need surgical treatment; *eg,* as demonstrated by a history of recurrence or complications, and in patients with concomitant illness in whom surgery would constitute a greater than usual risk. Limitation of use to this population is recommended because the consequences of very long-term use; *ie,* beyond one year of continuous Tagamet® therapy, are not known."

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Past President Treffert . . .

Report to the House of Delegates as President

Caring about people as well as for them

It is traditional that the President's report to the House of Delegates looks back at the course plotted out one year earlier for the year ahead and to recite how one has carried out those directions set forth as President-elect. For me, however, it would be hard to measure the impact of Many Moons, Sidewalks, and the Little Village By The Sea of last year. Even if I could do that, though, I would prefer to look forward, rather than backward, in this my final address as your President and share some recommendations for the future gleaned from this tremendous opportunity you have given me this past year.

The role of the President is more like that of a consultant, rather than an attending physician, since realistically, the work of the organization must go on in a consistent, continuous and non-whimsical fashion. Necessarily, the President can no more take over the management of the State Medical Society during his brief tenure than a consultant can take over the management of a patient based on one brief encounter and interaction. That being the case then, let me in this report give you my findings and recommendations based on my one year "consultancy" as your President, based on the brief glimpse at indeed what is a complex profession, organization, and healthcare system.

FINDINGS

As far as the State Medical Society of Wisconsin is concerned, I find it to be in excellent health, not without its minor symptoms and discomforts, but basically in sound shape for a 139-year-old. I find spirits, morale, and sense of worth to be more than adequate, and the day-to-day fluctuations in mood within our profession and organization are well within normal limits considering the times and the circumstances. A 1978 Gallop Poll of 1530 men and women in home interviews showed that 87% of consumers were satisfied with their personal doctor and their most recent medical experience. I doubt whether many other professions could presently match that percentage.

As far as the healthcare system in Wisconsin is concerned, it too is, in my opinion, in basically sound shape. Not without its problems, to be sure, but the quantity and quality of healthcare available to the citizens of this state has never been higher. Wisconsin, like other states in America, saw the 1970s bring 2.3 additional years to life expectancy (from 70.9 years to 73.2 years); saw a decline in death rate from heart disease of 17%; saw a drop in infant mortality rates from 20 per 1000 to 14.1 per 1000; saw length of stay in hospitals decline in every category of disease. No where is that decline more evident than in my own specialty (psychiatry) where length of stay is measured now not in years, or even in months or weeks, but in *days!* The attention of the public is gradually turning from sickness to health, and from focusing merely on quantity of life measured in longevity toward quality of life measured in serenity, comfortableness, and what I choose to call Mellowing.

There is one problem, though—that is the cost of that quantity and quality of healthcare. When asked to name the most important problems facing healthcare, 66% of the first-mentions among the public in the Gallop Poll mentioned above were cost references. Yet, while the public is extremely concerned with out-of-pocket medical costs, consumers do *not* feel that we as a society are spending too much on healthcare; and in fact that Poll pointed out that healthcare is the only area tested for which a majority of the public felt we as a society should be spending *more* money. Doctors, when asked similar questions, pointed out that physicians, too, felt that the cost of medical care was the overriding concern in the United States as they looked at the problems facing medicine and healthcare. Thus, a majority of physicians and the public considers cost, not quality, not

Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, March 27-29, 1980, in Milwaukee.

quantity, not access, as the biggest problem in healthcare today.

I agree. So much for the findings; now the recommendations.

RECOMMENDATIONS

Nothing is more frustrating to an attending physician than to get from a consultant only general and global recommendations that lack specificity. So at the risk of being simplistic and myopic, I offer several recommendations based on my "consultancy," both to the public and to our profession, realizing full well these are only a small part of the solution to very complex problems, reminiscent of Raymond Brauer's observation in an article in the *Futurist:* "The problem is akin to that of how one can eat an elephant. The only answer is that one might begin by biting the elephant. And, considering the magnitude of the test, it is difficult to argue that one place is better than another for the biting to start. And, after a considerable amount of biting has taken place, the elephant remains largely unscathed."

First, recommendations about the healthcare system for the public consumer:

(1) Balance *purchasing* healthcare with *practicing* healthcare—rustproofing people.

It was Thomas Jefferson who noted that if one didn't have time to devote to staying healthy, one should set aside that time later to be ill. A very practical implementation of health knowledge is prospective medicine, what I call rustproofing people. While there is still much to be learned about the actual impact of modifying risk factors in particular illnesses, and while all the new wives' tales of wellness must now be sorted from the old wives' tales of illness, the fact remains that if the public simply used common sense with respect to the use (and abuse) of food, alcohol, tobacco, seat belts, activity and exercise, at least 75¢ of every health dollar would probably be available for some other purpose.

Let us for the moment just focus on one single factor: *Cigarette smoking.* Total mortality in various age groups (death from all causes) is about twice as high among cigarette smokers as among non-smokers. Of this excess mortality, 19% is due to excess death from lung cancer and 37% is due to excess mortality from coronary artery disease. At any given level of risk, the habit of cigarette smoking almost doubles that risk.

Two-hundred eighty deaths occur from lung cancer each day in this country and the incidence of this most lethal to man of all cancers is rising rapidly as more women take up smoking. One-hundred and one thousand deaths occur each year from cancer of the lung and 117,000 new cases appear each year. The linkage of lung cancer to cigarette smoking is clear.

Coronary artery disease is a leading national health problem, if not the leading national health problem, because it strikes down so many persons at so young an age. Cigarette smoking is unique among all risk factors in coronary artery disease. Unlike serum cholesterol and blood pressure, where doubt remains about the potential efficacy of their alteration, the scientific conditions prerequisite to launching a massive public health program against cigarette smoking have been met. It has been demonstrated that the cigarette smoking habit increases the risk of coronary artery disease, that the habit can be altered, and that abandoning the habit will reduce the risk. The Chicago Coronary Prevention Evaluation Study indicated that "continued cigarette smoking is associated with a very high risk of premature death for coronary-prone men and that other preventative measures are by themselves of limited value . . . as long as they fail to give up cigarette smoking . . ."

Because it is much easier not to start smoking than to stop, our clinical efforts toward prevention of coronary heart disease should be directed primarily toward the pediatric age group, especially since it takes a few years for the beneficial effects to appear. Although it is never too late to stop smoking, it is much better not to start the habit at all. Our task, therefore, becomes one of convincing teenagers not to start smoking. Maybe it is too late for those already committed to the habit, but it is not too late to begin a really creative and effective counter-campaign against smoking with children.

Of all the things we could teach our children about their health and maintenance—rustproofing themselves—the one bit of advice most certain, most documented, and most demonstrated to be health-effective would be to present them with data, with advertising, with persuasion, and with models TO NOT SMOKE.

"Wellness" will remain merely a slogan and a possibility if the public does not take its responsibility seriously, and stopping cigarette smoking is clearly the demonstrated place to begin.

(2) From first dollar coverage to deductibles.

Deductibles are a way of decreasing utilization of healthcare resources and facilities; first dollar coverage is a way of increasing utilization of those facilities and resources.

It has been demonstrated repeatedly in other forms of insurance—auto, fire, and other forms of casualty insurance—that deductibles cut down on utilization of benefits and as a result, reduce premiums. First dollar coverage is, in my opinion, counter-productive to the goal of decreasing over-utilization of healthcare resources. Industry has learned some time ago that if one wants to cut down on abuse of sick leave, one adopts a policy where the first two days of sick leave are on the employee's own time—a form of deductible—and sick leave then begins only after the first two days of illness. The State Medical Society health insurance plan for its own members uses a deductible as a prudent and responsible method of assuring coverage for truly

costly procedures or hospitalizations, yet having the patient participate as a partner in paying for that utilization. It has been demonstrated that unnecessary over-utilization of the emergency room is likewise cut down with the use of deductibles.

Moving away from first-dollar coverage would, in my opinion, be another thing the public could do on its own behalf toward dealing with escalating medical care costs.

(3) Maintain a public/private partnership.

The electrical and plumbing trades union in England has just negotiated an astonishing fringe benefit in the land of socialized medicine—a complete package of *private* healthcare benefits for 45,000 members and their families. IBM just purchased private health insurance benefits for its entire British work force of 15,000; previously only a small group of 600 executives had been covered. Surely there must be some lesson in that, as we struggle in this nation to decide whether healthcare should be private enterprise, a utility, government regulated, or government operated. When 45¢ of every dollar spent for purchasing healthcare is being spent by local, state, or federal government, it is unreasonable for physicians to expect that government would not be interested in on whom, why, and in what manner that health dollar is being spent. The answer is, it seems to me, not a private versus public outcome, but rather some partnership between the private sector and the public need. I spoke before of the need to rearrange our sidewalks—our routes of access to and passage through the healthcare system rather than tearing the building down because the sidewalks are in the wrong place.

We need—the public and medicine together—to embark on a rearranging of our sidewalks. Physician distribution is but one such rearrangement and I would direct you to the recently completed, excellent paper on physician distribution completed by the Ad Hoc Committee on Physician Distribution and an example of what can usefully be put forth as sensible recommendations when physicians participate in planning and problem-solving rather than merely standing by as national norms and national formulas are mercilessly applied by planners who know the cost of things, but not the value of things.

Now some recommendations for us and our organization:

(1) Membership.

Only one out of three doctors in this country belongs to the American Medical Association and only one out of two is a member of a state or county medical society. Granted many of these outside organized medicine are still in training, are retired, or are engaged in some other non-patient care activity, yet, even so, only by increasing membership can we resist the pattern of fewer and fewer carrying proportionately more of the load and only can we thus keep up with inflation affecting our own organization such that we can only decrease benefits or increase dues.

William Wrigley once said, "If two people in an organization always agree with each other, one of them is unnecessary." To that extent, some divided opinion, and differing views are healthy and keep an organization vibrant. To that extent also, divided opinion on the unified membership question is understandable, predictable and, I feel healthy and natural.

I have listened carefully to the debate on both sides. There is no question but that the American Medical Association is essential at a national level, if medicine is to continue to shape its destiny, rather than be merely shaped by it. There is no question but that if we do not preserve a unanimous national voice, we will be fragmented and ineffective in trying to maintain physician input into the planning process and delivery function. There is no question but that we need as solid and unified a national voice as we have successfully effected a state voice in Wisconsin. The question then is not whether the American Medical Association is a useful organization, the question is merely whether unified membership is the best route to maintain the potency of the American Medical Association. Forty-five of the fifty states have said it is not. The AMA itself is seriously considering a reorganization which would make the AMA a federation of state medical societies wherein the state societies would be the basic membership unit, rather than individual members. This would be patterned after many other national organizations wherein membership is with the basic local unit or chapter and the national dues are paid on a capitation basis. This whole matter of reorganization will be debated at the AMA's annual meeting in 1980.

I respect the deeply held opinions on both sides of this important issue by each member. Frankly, the State Medical Society of Wisconsin will survive either outcome of this vote, as will the American Medical Association. I think the dire consequences on both sides of this issue have been exaggerated and the prophets of doom on both sides of that issue need to exercise more caution. The vote in fact may become moot as unified membership in other professional groups comes under the scrutiny of the court.

Clearly, a stronger American Medical Association is an absolute necessity, but the unified membership route of attaining that strength has not been shown to be effective. It appears some other mechanism will need to be developed to give AMA a national strength it has had in the past, and needs to maintain in the future. We face a clear predicament in view of the fact that only five states still retain unified membership and that predicament mandates a reconsideration and reorganization. In those states where non-unified membership has been adopted, state medical society membership has risen 12% between 1972 and 1978; whereas in the five unified states,

membership has risen only 9% in that same period. It is of concern that some physicians are kept outside organized medicine in unified states, at the state and county level, because of the unified membership requirement and to that extent, unified membership works as a deterrent to the State Medical Society of Wisconsin and county society membership, which also must remain strong. Perhaps the AMA could do something to differentially reward those states that maintain unified membership, since unified membership works to the detriment of those state societies in terms of their membership where the unified requirement is in force.

Those of us in leadership positions recognize the necessity of an even stronger AMA. Yet, the unified membership requirement needs to be looked at carefully, as it will be at this meeting, since it does not seem to be the mechanism to achieve that, and to some extent in fact, it keeps physicians in this state outside organized medicine—a predicament we cannot afford at any level. The point is that unified membership deserves a reasonable look at this point by this body and both SMS and AMA can survive whatever the outcome. There certainly is a need for unity. Whether unified membership is the manner in which to achieve that unity needs to be carefully weighed and then this organization needs to respond to the wishes of the majority of this democratic body, and then needs to get on with the other important work of this organization. More important, in my opinion, than the unified membership issue is the clear need to establish a student membership candidate classification with representation in the House of Delegates.

(2) Continuous physician input within SMS.

We have a fine organization in SMS, a responsible organization with very dedicated members and a very competent and dedicated staff. We are fortunate indeed to have Earl Thayer as Executive Secretary to provide the continuity from year to year and to give us his depth of continuity and breadth of vision because of his involvement with so many other similar State Medical Society executives around the country. The staff depends, as it must, on the medical leadership from the House, the Council, the officers, and committee and commission chairmen. Each of us in leadership positions must bear in mind the difference in our practices and in our organization between delegation, relegation, and abdication. Members must continue to provide and insist on a strong sense of direction and purpose so that the staff can carry out their heavy responsibilities in enacting the policies which we ourselves develop.

To that end, one clear need I see is a much closer relationship between the specialty societies in this state and SMS. I have recommended, and would strongly urge, there be a formal, ongoing, regularly-occurring meeting format for leadership of SMS with the presidents and officers of each of the specialty organizations in the state, whether or not those officers are SMS members. In most cases they are. This is not a substitute for, but a fortification of, the specialty sections within SMS.

(3) Care about patients as well as for them.

The reason for the survival of our profession has always been and will continue to be, quality patient care. Whatever else we do, we dare not change our unrelenting focus on doctor/patient care, one-on-one. That is the essence of medicine, its creation, its continuation, its purpose, and its perpetuation. Quality patient care—competent, compassionate, dedicated and gentle—is the essence of what we must do and is the essence of what has preceded and what must follow.

I referred you to James Thurber's *Many Moons* last year as the finest book on communication and medical diagnosis ever written. At the risk of your suspecting that I only read children's books, and not medical tomes, I would like, as my final recommendation, to refer you to another children's book which, along with *Many Moons* ought to be in every doctor's office—yes, office, not waiting room. The book is *The Little Prince* for it speaks to the essence of the doctor/patient relationship.

The Little Prince points out the perils of a profession:

(a) The "businessman" who "naturally interested in matters of consequence" would "administer them, count them and recount them."

(b) The "lamplighters" who blindly obey and unquestionably carry out even the absurd because "there is nothing to understand, orders are orders. I follow a terrible profession. In the old days it was reasonable."

(c) The "geographers" who write only of eternal things and ignore the ephemeral—"The thing that matters to us, of great consequence, is the mountain for it does not change. We do not record things ephemeral."

(d) The "railroad switchman," sorting out travelers in bundles of a thousand, sending off trains that carry them now to the right and now to the left."

(e) The "merchants" who sell pills to quench thirst "because they save a tremendous amount of time—with these pills you need only one pill per week and you need never to drink. You save 53 minutes in every week. What do you do with these 53 minutes?" "Whatever."

But we also have within our profession the wisdom, the possibility and the gentleness of the fox when he talks to the Little Prince, for we, too, three million patient episodes per day in this country, have the possibility to "tame."

"What does that mean, tame?" asks the Little Prince.

"It is an art too often neglected, it means to establish ties," replies the fox.

"To establish ties?"

"Just that. To me you are nothing more than a little boy who is like 100,000 other little boys. And I have no need of you. And you on your part have no need of me. To me I am nothing more than a fox, like another 100,000 other foxes, but if you tame me, then we shall need each other. To me, you will be unique in all the world. To you, I shall be unique in all the world. If you tame me, it will be as if the sun came to shine on my life. I shall know the sound of a step that will be different from all the others. Other steps send me hurrying back underneath the ground. Yours will calm me, like music, out of my burrow. And then look: See the grain fields down yonder? The wheat fields have nothing to say. And that is sad. But you have hair that is golden. Think of how wonderful that will be when you tame me. The grain which is also golden, will bring back the thought of you. And I shall love to listen to the wind in the wheat. Please tame me."

"I want to, very much, but I have not much time. I have friends to discover and a great many things to understand."

"One only understands the things that one tames. Men have no more time to understand anything. They buy things already made at the shops. But there is no shop anywhere where one can buy friendship and so men have no friends anymore. If you want a friend, tame me."

"What must I do to tame you?"

"You must be very patient. First, you will sit down at a little distance from me—like that—in the grass. I shall look at you out of the corner of my eye and you will say nothing. Words are the source of misunderstandings. But you will sit a little closer to me every day. *Here is the secret, a very simple secret: It is only with the heart that one can see rightly; what is essential is invisible to the eye.* It is the time you have wasted for your rose that makes your rose so important. Men have forgotten this truth. But you must not forget it. You become responsible, forever, for what you have tamed."

We in our profession can tame. Then each and every patient is not like 100,000 other patients. And we, to our patients, are not like 100,000 other doctors. We, and our patients, become unique to each other. And in healing we come to realize there too, so much of what is essential is invisible to the eye and, by establishing ties, we not only tame, but we become responsible for that which we have tamed.

I appreciate deeply the opportunity to have been your President this past year. To the extent that I could, I attempted to keep us on a course where the route seemed proper; to the extent that I could, I attempted to adjust the course where it seemed to be deviant. That's about all one can do in a single year—not reach the destination but perhaps adjust the compass of the organization a bit. I have tried to do that as best I could. I trust it has been satisfactory.

I consider it a privilege to have been your President. ■

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Organizational SMS

Council approves creation of a speakers' bureau

The Council, at its March 26 and 29 meetings in Milwaukee during the SMS Annual Meeting, approved a proposal of the Commission on Public Information to create a speakers' bureau for the purpose of increasing public awareness of the Society and its activities on behalf of patients.

Such a speakers' bureau would include the principal officers of the Society and other appropriate representatives who would make "Community Relations Appearances" before civic groups in key media centers in the state. They also would be available for editorial meetings in each location with editors, news directors, and key media persons. The House of Delegates concurred with this recommendation.

In other action March 26 and 29 the Council:

- Received and approved the first half of a report discussing physician distribution in Wisconsin prepared by an ad hoc committee of the Council. The Council also appointed a committee of five physicians to review and/or modify the final portion of the report containing recommendations on physician distribution prior to the May Council meeting. The physicians are MDs Kermit L Newcomer, LaCrosse; Darold A Treffert, Fond du Lac; John J Kief, Rhinelander; John U Peters, Fond du Lac; and Russell F Lewis, Marshfield.
- Merged the SMS committees on Environmental Health, Rural Health, and Occupational Health into a single Committee on Environmental Health.
- Went on record as opposing submission of any part of the decertification rule on open heart/cardiac catheterization services to the legislative review process until the technical advisory committee has had full opportunity to review the entire rule draft and offer corrective changes.
- Adopted a recommendation of the SMS Committee on Maternal and Child Health supporting the use of silver nitrate, tetracycline, or erythromycin as acceptable prophylactics for the prevention of gonococcal ophthalmia neonatorum.
- Held elections as reported in the April issue.
- Made several physician appointments and reappointments to SMS commissions and committees as reported elsewhere in this issue.
- Set meeting dates for the year on May 17, July 12, September 27, November 15, 1980; and January 24 and March 25, 1981. ■

Museum of Medical Progress reopens May 1-October 31

Looking for an enjoyable yet educational outing for you and your family? Why not visit the Museum of Medical Progress in Prairie du Chien?

Owned and operated by the State Medical Society's Charitable, Educational and Scientific Foundation, the Museum reopened for the 1980 season on May 1.

This season also marks the reopening of another important component of the Museum—the Stovall Hall of Health. A unique health education facility, Stovall Hall of Health contains a wide array of audiovisual exhibits exploring such subjects as the birth of a baby, the functioning of the human body, effects of alcohol on the brain, health careers, immunization, and teenage nutrition.

The Fort Crawford Military Hospital, a national historic landmark, will take physicians and their families back into 19th century medicine in Wisconsin. A remembrance of military life in early Prairie du Chien, its rooms capture the fort physician and the "horse and buggy" doctor of days past. Displays of Indian herbal remedies, a reconstructed 1890's pharmacy, and 19th century dentist and physicians' offices also will be found here.

The Fort Crawford Military Hospital and Stovall Hall of Health will be open this year from May 1 through October 31, from 10 am to 5 pm daily. Admission is $1.00 for adults and 50¢ for children. ■

New field consultant joins Society PA staff

Timothy H Lynch has joined the SMS staff as a field consultant for the Physicians Alliance Division.

Lynch will serve in a new district—district 6—which will comprise the counties of Ozaukee, Waukesha, Racine, Kenosha, and Walworth. In addition, he will assist another field consultant, Lois Riley, in Milwaukee County as a secondary assignment.

A Milwaukee native, Lynch most recently served on the congressional staff of Rep James Sensenbrenner as a legislative analyst. Prior to that time he worked in the State Assembly as an aide to former State Rep Steve Gunderson. He was a Republican candidate for the 10th Assembly District in 1978. ■

Elections: House of Delegates, Council

The House of Delegates elected (E) or reelected (R) the following physicians to these positions:

President-elect (1980-1981):
Albert J Motzel Jr, MD, Waukesha (E)

Speaker (1980-1981 — to complete unexpired term of Doctor Motzel):
Duane W Taebel, MD, LaCrosse (E)

Vice-speaker (1980-1981):
Chesley P Erwin, MD, Milwaukee (E)

AMA Delegates (1981-1982):
John K Scott, MD, Madison (R)
Patricia J Stuff, MD, Bonduel (R)
DeLore Williams, MD, West Allis (R)

AMA Alternate Delegates (1981-1982):
Richard W Edwards, MD, Richland Center (R)
Cornelius A Natoli, MD, La Crosse (R)
John D Riesch, MD, Menomonee Falls (R)

Councilors:

DISTRICT 1
Carl S L Eisenberg, MD, Milwaukee (R)
Thomas A Hofbauer, MD, Menomonee Falls (E)
(succeeding Daniel K Schmidt, MD, Milwaukee)

DISTRICT 3
Pauline Jackson, MD, LaCrosse (R)

DISTRICT 4
John J Kief, MD, Rhinelander (R)
Jung K Park, MD, Wisconsin Rapids (R)

DISTRICT 5
Timothy T Flaherty, MD, Neenah (R)

DISTRICT 6
Roger Von Heimberg, MD, Green Bay (E)
(succeeding Antoine Barrette, MD, Peshtigo)

DISTRICT 7
Paul S Haskins, MD, River Falls (R)

The Council elected (E) or reelected (R) the following physicians to these positions:

Chairman of the Council:
Darold A Treffert, MD, Fond du Lac (E)
(succeeding Paul S Haskins, MD, River Falls)

Council Vice-chairman:
Timothy T Flaherty, MD, Neenah (R)

Secretary and General Manager of the Society:
Earl R Thayer, Madison (R)

Treasurer of the Society:
Richard W Edwards, MD, Richland Center (R)

Assistant Treasurers of the Society:
Eugene J Nordby, MD, Madison (R)
Abraham A Quisling, MD, Madison (R)
H Kent Tenney, MD, Madison (R)

The Council, considering recommendations of the Nominating Committee, appointed (A) or reappointed (R) the following physicians to commissions and committees of the Society, with terms expiring in 1983 unless otherwise indicated:

Commission on Continuing Medical Education
Martin Z Fruchtman, MD, Waukesha (R)
George A Berglund, MD, Milwaukee (R)
John J Koch, MD, Prairie du Sac (E)
(replaces Joseph C Darin, MD, Milwaukee)

Commission on Public Information
Joseph W Edgett Jr, MD, LaCrosse (R)
Mark J Popp, MD, Brookfield (R)
William J Maurer, MD, Marshfield (R)

Commission on Governmental Affairs
Robert F Purtell Jr, MD, Milwaukee (R)
Jack D Edson, MD, Eau Claire (R)
Raymond C Zastrow, MD, Wauwatosa (R)
Gerald A Gehl, MD, Neenah (E) (for unexpired term of Ralph L Suechting, MD, Neenah, 1981)

Commission on Health Planning
Marvin G Parker, MD, Racine (R)
John H Renner, MD, Madison (R)
Frederic L Hildebrand, MD, Neenah (R)

Commission on Mediation and Peer Review
Charles E Koepp, MD, Marinette (R)
Herman J Dick, MD, Sheboygan (R)
Harry F Weisberg, MD, Milwaukee (R)
Robert E Johnston, MD, Green Bay (R)
Richard Logan, MD, Madison (R)
Melvin F Huth, MD, Baraboo (R)
Mark Lochner, MD, Waupaca (R)
David Westgard, MD, LaCrosse (R)

Wisconsin Medical Journal
Melvin F Huth, MD, Baraboo (R)
Victor S Falk, MD, Edgerton (R)

MEDICAL EDITOR (1980-1982)
Victor S Falk, MD, Edgerton (R)

EDITORIAL DIRECTOR (1980-1981)
Wayne J Boulanger, MD, Milwaukee (R)

EDITORIAL ASSOCIATES (1980-1981)
John P Mullooly, MD, Milwaukee (R)
Brenton H Field Jr, MD, Milwaukee (R)
T H McDonell, MD, Waukesha (R)
Raymond A McCormick, MD, Green Bay (R)

Physicians Alliance Commission
LaVern H Herman, MD, Waukesha (R)
William L Treacy, MD, Milwaukee (R)
Charles E Pechous Jr, MD, Kenosha (R)
Jordon Frank, MD, Beloit (R)
Jack Lockhart, MD, LaCrosse (A) (replaces Charles N FordJr, MD, LaCrosse)
Robert Jackson, MD, Madison (A) (for unexpired term of Frederick C Kriss, MD, 1981)

Committee on Aging and Extended Care Facilities
Joseph Springberg, MD, Beloit (R)
Frederick W Blancke, MD, Madison (R)

Committee on Alcoholism and Other Drug Abuse
Darold A Treffert, MD, Fond du Lac (R)
Michael Gordon, MD, Janesville (A) (replaces Eugene J Kinder, MD, Spring Green)
Dennis Biros, MD, LaCrosse (A) (replaces Edward C Schmidt, MD, Milwaukee)

Committee on Maternal and Child Health
James C Tankersley, MD, LaCrosse (R)
John E Inman, MD, Monroe (R)

Committee on Medicine and Religion
Maxwell Weingarten, MD, Milwaukee (R)
John K Scott, MD, Madison (R)
E Basil Jackson, MD, Milwaukee (R)
William O Myers, MD, Marshfield (A) (for unexpired term of Roger Evans, MD, LaCrosse, 1981)

Committee on Mental Health
Francis M Forster, MD, Madison (R)
Edward Meyer, MD, Oshkosh (R)

Committee on School Health
William T Brodhead, MD, Madison (R)
Frank Walker, MD, Brookfield (R)
Lawrence K Siegel, MD, Waukesha (R)
Jack Spear, MD, Richland Center (A) (for unexpired term of Dennis K Ryan, MD, LaCrosse, 1982)

Committee on Safe Transportation
Clarence E Moore, MD, Fond du Lac (R)
James M Huffer, MD, Madison (R)
Elmer E Johnson, MD, Madison (R) ■

New President-elect

Albert J Motzel Jr, MD, Waukesha

Graduate of St. Louis University Medical School. Served internship at Milwaukee County Hospital in 1953-54 and residency in surgery at Milwaukee County Hospital in 1954-1958. Received license to practice medicine in Wisconsin in 1954. Has been in practice of general surgery in Waukesha since 1958. Has been a diplomate of the American Board of Surgery since 1959. Is clinical instructor in surgery at Medical College of Wisconsin. Is on active staff of Waukesha Memorial Hospital, Waukesha, and on associate attending staff of Milwaukee County Hospital, Milwaukee. Is Director of Medical Education and coordinator of Medical Staff Affairs at Waukesha Memorial Hospital. Was president of Waukesha County Medical Society in 1972-1973. Has served as delegate from Waukesha County Medical Society to State Medical Society. Is a member of the Wisconsin Surgical Society, Milwaukee Academy of Surgery, Society for Computer Medicine, Association for Hospital Medical Education, and a member of the American Academy of Medical Directors. Is a fellow of the American College of Surgeons. Former director and vice-president of Board of Directors of Foundation for Medical Care Evaluation of Southeastern Wisconsin. Served 1975-1976 as House vice-speaker and House speaker from 1977 to 1980.

Doctor Hofbauer

Doctor Von Heimburg

Doctor Motzel

New councilors

DISTRICT 1

Thomas A Hofbauer, MD, Menomonee Falls

Born Sept 28, 1932 in Milwaukee, Wisconsin. Graduated from Marquette University School of Medicine in 1956. Served as a captain in the United States Army from 1957-1959. Licensed to practice medicine in Wisconsin in 1957. Doctor Hofbauer has been an active member of the State Medical Society since 1961 and served on the WPS Commission. Served as delegate to SMS from Waukesha County Medical Society. Doctor Hofbauer served as chief of the Department of OB/GYN at Community Memorial Hospital and also served as president of the medical staff. Elected to Council, March 1980, to serve the balance of term (1981) of Daniel K Schmidt, MD, Milwaukee, who resigned.

DISTRICT 6

Roger L Von Heimburg, MD, Green Bay

Born Feb 5, 1931 in Chicago, Ill. Graduated from Johns Hopkins University School of Medicine, Baltimore, MD in 1955. A general surgeon, Doctor Von Heimburg served his surgical residency at The Mayo Clinic, Rochester, Minn, from 1958-1964. He was licensed to practice medicine in Wisconsin in 1961. Certified by the American Board of Surgery in 1963. Has been active member of State Medical Society since 1964. Elected to Council, March 1980, for a three-year term.

LaCrosse area woman new president, SMS Auxiliary

Lila M Seager of Stoddard was installed as president of the Auxiliary of the State Medical Society of Wisconsin during the Auxiliary's Annual Meeting, running concurrently with the SMS Annual Meeting, March 27-29, in Milwaukee.

Mrs Seager succeeds Mary J Smigielski of Milwaukee. Mrs John F Vaughn, Vancouver, Washington, president-

elect of the Auxiliary of the American Medical Association, was the installing officer.

Married to a LaCrosse physician, Mrs Seager is a native of New Jersey. In 1969 she and her husband moved to the LaCrosse area and made their home in neighboring Stoddard. A former primary education teacher, Mrs Seager received her Bachelor of Science degree in Elementary Education from the University of Vermont and a Master of Arts degree from Columbia Teachers College, New York City, in educational administration.

The new Auxiliary president has been active in the LaCrosse community serving as president of the YWCA, on the State Board of the Sunburst Youth Homes, and as a member of the First Congregational Church.

She is a member of the Daughters of the American Revolution, the American Association of University Women, the Republican Women's Club and the Sierra Club. She is a former vice-president of the LaCrosse Chapter of the League of Women Voters.

A former secretary and president of the LaCrosse County Medical Society Auxiliary, Mrs Seager has also held several posts at the state Auxiliary level, serving as state secretary, vice-president, and president-elect. ■

Annual Meeting photos by SMS Staff: Neal Neuberger and Mary Angell

THIRTEEN OF THE THIRTY-EIGHT PHYSICIANS accepted in the Fifty Year Club were honored at the Presidents Dinner during the Society's Annual Meeting, March 28, in Milwaukee. Eleven of them are shown above, left to right: Doctors O'Neill, Curran, Schmidt, Colgan, Stern, Urben, Quisling, Ausman, Kruel, Herzog, and Rouse. Doctors Pollack and Miller were present but unable to stay for the picture.

1980 Fifty Year Club members

The State Medical Society annually pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity. This year there were 38 physicians so honored, as follows:

Donald C Ausman, MD, Milwaukee
Dewitt C Beebe, MD, Sparta
Marshall O Boudry, MD, Waupaca
Frances A Cline, MD, Rhinelander
John J Colgan, MD, Eagle River
Earl F Cummings, MD, Oshkosh
William P Curran Sr, MD, Deerbrook
Peter A Duehr, MD, Verona
Joseph V Herzog, MD, Sun City, Arizona
Amy L Hunter, MD, Green Valley, Arizona
Adolph M Hutter, MD, Madison
Edwin Hall Jorris, MD, Sarasota, Florida
Walter C Kleinpell, MD, Kenosha
Randolph W Kreul, MD, Racine
Israel H Lavine, MD, Superior
Howard J Lee, MD, Milwaukee
Kenneth E Lemmer, MD, Madison
Harold L Miller, MD, Milwaukee
Edward J O'Neill, MD, Milwaukee
Saul K Pollack, MD, Milwaukee
Paul J Purtell, MD, Milwaukee
Raymond H Quade, MD, Sedona, Arizona
Abraham A Quisling, MD, Madison
Martha Rosin, MD, Sturgeon Bay
John J Rouse, MD, Reedsburg
David D Ruehlman, MD, Sunnyvale, California
Albert C Schmidt, MD, Milwaukee
Leonard J Schneeberger, MD, Milwaukee
Isadore Schultz, MD, Mazomanie
Wilfrid L Seng, DDS, MD, Milwaukee
Joseph C Springberg, MD, Beloit
Charles S Stern, MD, Milwaukee
Walter J Urben, MD Madison
Hart E Van Riper, MD, Deerfield Beach, Florida
Maurice L Whalen, MD, Bruce
Robert M Wheeler, MD, Fort Lauderdale, Florida
David L Williams, MD, Madison
F Frank Zboralske, MD, Fall Creek ■

Summary Report, House of Delegates

State Medical Society of Wisconsin, March 27-29, 1980

THE FOLLOWING constitutes the summary report of actions taken at the Annual Meeting of the House of Delegates, March 27-29, 1980. Resolutions and reports were widely distributed to delegates, alternates, county society officers, and others. Members of the Society may, upon request, study the official transcript of the meeting at the State Medical Society headquarters in Madison, or inquire as to the full content of a particular report or resolution.

Earl R Thayer
Secretary

The House deliberated 28 resolutions as well as reports of officers, the Council, commissions, committees, and ad hoc committees. Refer to the February 1980 *Wisconsin Medical Journal* for abstracts of resolutions 1-20 and their sources. Eight additional resolutions were introduced at the first session on March 27, designated A through H. Following is the text of the House of Delegates reference committee reports (with additional commentary inserted where needed for meaning) and indication of House action upon their recommendations

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

•**Resolution 1** urging continuation of compulsory AMA membership is recommended for rejection because of the constitutional amendments before this House for action.

Action: Resolution rejected

•**Resolution 4** introduced in 1979 proposed amendment of Article IV of the State Medical Society Constitution to delete the words "who shall be members of the component medical societies, and who shall also be members in good standing of the American Medical Association, and". Your reference committee unanimously recommends rejection of this proposed amendment.

Action: Amendment rejected

•**Resolution 1** introduced in 1979 proposed amendment of the same Article IV of the Constitution to delete the words "and who shall also be members in good standing of the American Medical Association, and". Your reference committee recommends rejection of this proposed amendment by a vote of 4-1. Despite the lack of unanimity in this recommendation, the committee was unanimous in reaffirming the resolution adopted by the House last year that every member of the State Medical Society of Wisconsin be encouraged and advised to support the American Medical Association by membership and by continuing constructive participation in its affairs.

Action: The committee recommendation to *reject* this proposed amendment lost by a vote of 70-66. The vote on a motion to *adopt* the amendment (thus eliminating mandatory AMA membership) was 79-61, which was short of the two-thirds vote required to amend the Society's Constitution. (Article IV of the Constitution therefore remains unchanged at least until the 1981 meeting of the House of Delegates when it will act on a proposed general revision of the Constitution and Bylaws.)

•**Resolutions 2 and 3** were considered together, both dealing with student membership in the State Medical Society. Your reference committee recommends adoption of Resolution 3 with the final resolve amended to read "that the State Medical Society create a Medical Student Section with a voting delegate and alternate in the House of Delegates." (Three additional "resolves" relate to creation of a membership classification for medical students and unlicensed postgraduate physicians, which is contemplated in the proposed revision of the Constitution and Bylaws to be acted upon in 1981, and to establishment of a nominal membership fee and benefits.)

Action: Resolution 3 adopted as amended

Your committee recommends rejection of Resolution 2, having initiated implementation of its intent through Resolution 3.

Action: Resolution 2 rejected

•**Report of Ad Hoc Committee on Revision of the Constitution and Bylaws:** Your reference committee reports to the House that a proposed general revision of the Constitution and Bylaws of the State Medical Society of Wisconsin has been introduced in timely fashion. It recommends that consistent with Article XIII with reference to amendments of the Constitution, the entire report lie over for consideration and vote at the 1981 session.

Action: Recommendation adopted

•**Resolution 11** concerns smoking at SMS meetings. Your committee recommends adoption with an amendment so that it would read "that smoking be prohibited at all formal scientific or business meetings of the State Medical Society of Wisconsin."

Action: Adopted as amended

• **Resolution 17** concerns insurance advisory committees. Your reference committee recommends that the House of Delegates heed the advice contained in the Supplementary Report of the Council of March 27, and that Resolution 17 be rejected. (The Council reported information heard from the assistant general counsel of the American Medical Association, Miss B J Anderson, on current cases in which the AMA as well as other medical organizations and the FTC are involved. Miss Anderson noted that the FTC order currently prohibits any physician, group of physicians, or medical association, among others, from engaging in acts which the FTC feels unlawfully restrict competition. It is the recommendation of the AMA that if any segment of organized medicine has a committee to help third party payors determine what is a reasonable payment for a physician's service, that it stop this activity until the courts have finally ruled on the FTC order via the current AMA appeal.)

Action: Resolution rejected

• **Council Report T,** with the exception of several specific items referred to other reference committees, was reviewed. The committee recommends that the Council be complimented on its report and urges that all delegates read it, especially the appended summary of principal Council actions in the past year and the status report on 1979 House actions, which are valuable sources of information on the ongoing work of the Council.

Action: Recommendation adopted

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

• **Report A of the Committee on Safe Transportation** outlines the activities of the committee. The reference committee urges the committee to attempt to strengthen existing standards for school bus operators and recommends adoption of this report.

Action: Adopted

• **Report B outlines the activities of the Governmental Affairs Commission** relating to legislation. The reference committee commends Doctor Lubitz and the commission for their dedication and accomplishments. With regard to the Society's position on Assembly Bill 66 concerning nurse-midwives, the reference committee was informed that the Governmental Affairs Commission has changed one of the conditions for support to read "a physician trained in obstetrics" in lieu of the exclusive use of "obstetricians." Your reference committee recommends concurrence with this change and acceptance of Report B.

Action: Accepted

• **Report C of the Physicians Alliance Commission** enumerates the commission's accomplishments and future goals. The reference committee commends the Alliance for its aggressive efforts in helping to resolve Medicaid, professional liability and other socio-economic issues. The Physicians Alliance Commission advised the committee that on page one of its report, in paragraph six concerning actions by the WHCLIP Board of Governors, the word "opposed" should be "approved." In concurrence with this change, your reference committee recommends acceptance of Report B.

Action: Accepted

• **Report P of the Commission on Public Information** outlines the activities of the commission and delineates plans for the coming year (including creation of a medical speakers' bureau to increase public awareness of the Society and its activities

THANK YOU

The reference committees of the House of Delegates are to be commended for their thoughtful deliberations and thanked for a job "well done."

Reports of Officers
Russell S Pelton, MD, Ripon, *Chairman*
James B Kuplic, MD, Sheboygan
Donald E Riemer, MD, Cumberland
Thomas A Hofbauer, MD, Menomonee Falls
James J Tydrich, MD, Richland Center

Reports of Standing Committees
James N Moore, MD, Madison, *Chairman*
Marvin G Parker, MD, Racine
David L Nelson, MD, LaCrosse
Paul M Cunningham, MD, Appleton
James D Kramer, MD, Wausau

Resolutions and Amendments to the Constitution and Bylaws
Charles S Geiger Jr, MD, West Bend, *Chairman*
Raymond C Zastrow, MD, Wauwatosa
Roger L Von Heimburg, MD, Green Bay
Clarence M Scott, MD, Superior
Stephen B Webster, MD, LaCrosse

Finances
Paul G LaBissioniere, MD, Wauwatosa, *Chairman*
Karl E Walter, MD, Eau Claire
Richard L Myers, MD, Green Bay
R L Hansen, MD, Marshfield
Dolores A Buchler, MD, Madison

Credentials Committee
Lloyd P Maasch, MD, Weyauwega, *Chairman*
Sandra L Osborn, MD, Madison
William E Finlayson, Milwaukee

Albert J Motzel Jr, MD
Speaker

on behalf of patients). The reference committee recommends approval of the report.

Action: Adopted

•Report Q outlines activities and future goals of the Committee on Alcoholism and Other Drug Abuse. The reference committee recommends approval of the report.

Action: Adopted

•Report R of the Ad Hoc Committee to Review Physicians Alliance. This committee was appointed pursuant to action by the 1979 House of Delegates to study the Physicians Alliance. The reference committee recommends adoption of the report's recommendations and suggests they be referred to the Council for review and evaluation with special consideration to be given to Recommendations 7 and 19. (These recommendations

Attendance: 1472

Total attendance of the two-day scientific program, March 28-29, 1980 at MECCA in Milwaukee was 1472, up by 45 from 1979.

Registration of physician members was 959, 27 nonmember physician registrants, 35 guest physicians (which was slightly up from last year), while the balance consisted of 199 technical exhibitors; 58 scientific exhibitors; 62 interns, residents, and medical students; and 132 guests (certified nurses, physician spouses, and others), up substantially from last year.

The three sessions of the House of Delegates had the following registrations: 126 first session; 140 second session; and 111 third session. There are 156 voting members of the House.

Scientific exhibit awards

The following scientific exhibits were awarded first, second, and third ribbons (Citation of Merit Awards):

FIRST PLACE: (Two exhibits from Columbia Hospital)—*Percutaneous Trigeminal Thermal Rhizotomy for Tic Douloureux,* by David E Ostrow, MD and Michael A Maradik, RBP, Columbia Hospital, Milwaukee; and *Regional Chemotherapy of Hepatic Metastases from Colorectal Cancer,* by William L Donegan, MD and Michael A Maradik, RBP, Columbia Hospital, Milwaukee.

SECOND PLACE: *Creatures That Bite in the Night,* Stephen B Webster, MD; Cornelius A Natoli, MD; and Diana M Uhler, RN, The Adolf Gundersen Medical Foundation and The Coulee Region Chapter of March of Dimes.

THIRD PLACE: *Complete Vastus Lateralis Obliquis Tendon and Lateral Capsular Resection for Patellofemoral Instability,* by Bruce J Brewer, MD and Roger Paul Johnson, MD, Department of Orthopaedic Surgery, Medical College of Wisconsin, Milwaukee.

Doctor Wasserburger honored posthumously

Doctor Treffert and Mrs Wasserburger

The Distinguished Service Award of the State Medical Society of Wisconsin was presented Mrs Richard H Wasserburger on behalf of her late husband Richard H Wasserburger, MD, Madison, March 28 in Milwaukee. Doctor Wasserburger was honored posthumously "for his outstanding contributions to the science and art of medicine through his many years of teaching at the University of Wisconsin Medical School and for his internationally renowned contributions to electrocardiography research."

SMS President Darold Treffert, MD in presenting the award to Mrs Wasserburger said "practicing physicians admired Doctor Wasserburger for his unfailing dedication to continuing medical education, and for his ability to instill the science and art of medicine into the minds and hearts of the students he taught. He was truly an enthusiastic and gifted teacher."

Doctor Wasserburger was Chief of Cardiology and Assistant Chief of Medicine at the Madison Veterans Administration Hospital, while a member of the UW medical faculty. At the time of his death on September 16, 1979, he was Director of the Statewide Electrocardiography Program of University Hospitals, a program he initiated.

The Commission on Continuing Medical Education, upon approval of the Council, grants the Distinguished Service Award to acknowledge outstanding contributions to the science and art of medicine by individuals engaged in teaching and research in the basic sciences.

Surgeon's award goes to Dr George Block

"A Surgical Perspective of Inflammatory Bowel Disease" was the title of a presentation made to Wisconsin surgeons March 29 by George E Block, MD, professor of surgery at the University of Chicago Medical Center, Chicago, during the SMS Annual Meeting in Milwaukee.

Doctor Block made his presentation at the William Beaumont Memorial Lecture, a yearly event sponsored by the Society's Charitable, Educational and Scientific Foundation "to honor distinguished medical scientists whose research and clinical experience enrich the knowledge and skills of Wisconsin practitioners."

CESF Treasurer Leland C Pomainville, MD, Wisconsin Rapids, presented Doctor Block with the Beaumont Award plaque.

The William Beaumont Memorial Lecture is given in the honor of Dr William Beaumont, a United States Army surgeon, who in the early 1800s performed a series of experiments which laid the foundation of our knowledge of digestion.

Doctor Picard

Society's highest honor goes to Doctor Charles Picard

" 'If there's a job to be done, Charlie can do it.' These words were once used by the Wisconsin Academy of Family Physicians to describe Charles J Picard, MD, Superior, as a nominee for the presidency of that organization. They are words that tell the story of Doctor Picard's life as a physician, as a citizen in his community, as a servant to his patients, his state and his profession," said Council Vice-chairman Timothy T Flaherty, MD, Neenah, in presenting the 44th Council Award to Doctor Picard Saturday, March 29 in Milwaukee.

The Council Award is the highest honor of the Society and is granted only to those individuals who have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Doctor Flaherty said "that during Doctor Picard's more than 44 years as a physician, there has been no task too forbidding to callup his effort, no task too small to command his attention."

"Throughout his years of service of medicine, Doctor Picard was known as the listener, the learner, who always kept an eye toward answers to medicine's problems," said Doctor Flaherty.

Doctor Picard served as president of the State Medical Society of Wisconsin from 1976 to 1977, as a delegate to the American Medical Association from the State Medical Society from 1969 to 1974, and as an alternate delegate from 1963 to 1968.

After graduating from Marquette University School of Medicine in 1936, Doctor Picard was with the US Public Health Service Indian Division from 1936 to 1941, when he moved to Superior to begin his private practice—a practice he actively maintains today.

"A man who always went about his work in a quiet, unassuming manner, never seeking public attention for his efforts, Doctor Picard has devoted countless hours to counseling young people in his community. Additionally, he has been active in state and community affairs, serving as vice chairman of the Wisconsin Heart Association, Superior city health officer, medical director of the Douglas Community Blood Bank and chairman of that county's School Health Association.

"Using his personal experience as physician who happened upon a devastating auto accident scene, did his best to assist, and was later sued for his efforts, Doctor Picard played a major role in the passage of the state's first Good Samaritan law in 1963.

"Being part of the solution and not part of the problem is the basic philosophy by which Doctor Picard lives," said Doctor Flaherty, "and this philosophy was markedly evident over years of dedication and service to patients, the profession and the public."

are: (7) Consider a name change to avoid confusion among the Physicians Alliance Commission, Physicians Alliance Division, and WisPAC; and (19) Every five years, or more often if desired by the House, a committee such as this should be set up to review activities because such a significant portion of the budget is committed to this project.)

Action: Adopted and referred to Council

•Resolution 8 recommends legislation dealing with penalties for forged prescriptions. The reference committee believes that the current law is adequate and recommends the following substitute resolve: "That the State Medical Society of Wisconsin urge more aggressive enforcement of existing laws dealing with forged prescriptions."

Action: Substitute adopted

•Resolution 12 deals with psychotherapy services under the Wisconsin Medical Assistance Program. The reference committee recommends adoption of this resolution with an amendment in item (1) of the resolve to read as follows: "(1) The State Medical Society of Wisconsin recommends that all physicians provide psychotherapy when indicated in the best interest of their Title XIX patients." (This amendment deletes the words "presently providing psychotherapy continue to" following the word "physicians." The resolve includes four additional measures intended to bring about the elimination of the current psychotherapy rule of the Wisconsin Department of Health and Social Services.)

Action: Adopted as amended

•Resolution 13 calls for elimination of the (Medicaid) Provider Agreements. The reference committee recommends the resolution not be adopted since federal regulations mandate provider agreements.

Action: Resolution rejected

•Resolutions 14 and 15 deal with reimbursement for physicians' services on a single statewide area basis. The reference committee recommends rejection of these resolutions on the basis that they conflict with current FTC regulations.

Action: Resolutions rejected

•Resolution 16 relates to physician distribution/reimbursement. The reference committee notes that this is already House policy, but for purposes of clarification recommends the following substitute: "Resolved, That the State Medical Society of Wisconsin supports the establishment of fee structures throughout the state that are equitable and foster physician distribution." (The original resolution was to "support a policy to establish. . .")

Action: Substitute adopted

•Resolution 18 dealing with health insurance deductibles and coinsurance deserves the special commendation of this House for its efforts in the area of cost containment. The reference committee recommends its adoption. (The resolves, in summary, encourage the concept of significant deductible and coinsurance options in health insurance policies; propose that the Society-sponsored plan offer significant deductibles as an option; and that the Society undertake a program to educate its members and the general public to the economics of such options.)

Action: Adopted

•Resolution 19 deals with professional liability insurance. The reference committee recommends adoption of the first resolve "that the State Medical Society seek the establishment of a separate board of directors to control and manage the Patients Compensation Fund," and the following substitution for the second: "that the State Medical Society of Wisconsin continue to investigate a physician sponsored professional liability insurance company to work cooperatively with the Fund in the protection of physician and patient interests."

Action: Adopted as amended

•Resolution 20, dealing with Patient Compensation Panels, was introduced by the Physicians Alliance Commission and the reference committee recommends its adoption. (The resolution in substance reaffirms support for the Patient Compensation Panel system, encourages all members to serve when called, and requests specialty societies and sections to assist in securing physician participation in panel proceedings.)

Action: Adopted

•Late Resolution B calling for a study of the validity of chiropractic was introduced by Councilor Wayne Boulanger on behalf of the First District Delegation. The reference committee notes that the Governor's Health Task Force conducted such a study in 1972 and its findings remain available to the Legislature and the public. It therefore recommends that the resolution not be adopted.

Action: The recommendation was defeated following discussion, and the resolution was adopted "that the State Medical Society urge that the Wisconsin Legislature, through its regulatory bodies, instruct the University of Wisconsin to conduct a complete study of chiropractic to determine its validity and submit its report to the Legislature following completion of the study."

• **Late Resolution D,** introduced by Councilor Carl Eisenberg on behalf of the First District Delegation, **relates to Media Announcements of Premiums and Benefits by Third Party Payors.** The reference committee recommends that it be adopted.

Action: Adopted as follows (whereas clauses omitted)

RESOLVED, That the Wisconsin State Medical Society and its component societies remind Surgical Care-Blue Shield and all other third party payors, wherever necessary, of their right to establish premium amounts and define benefits, but not to set physician fee levels or fee ceilings or otherwise tamper with the freedom of the market place and the evolution of "usual and customary" levels; and be it further

RESOLVED, That Surgical Care-Blue Shield and any other third party payor, if necessary, be requested to avoid the implication that it is empowered to set fees in communications to the media or subscribers; and be it further

RESOLVED, That Surgical Care-Blue Shield be requested to refrain from advising subscribers that they need not pay physician fees which exceed Surgical Care-Blue Shield payment allowances; and be it further

RESOLVED, That physicians reaffirm their right to establish "reasonable" fees individually, competitively and without interference, a freedom enjoyed by other segments of the American free enterprise system.

Outstanding medical students honored

Robert T Cooney, MD, CESF President, and Jose Luna

The Doctors Houghton Award this year went to Jose Luna, a senior at the Medical College of Wisconsin and Lori Neumann, a senior at the University of Wisconsin Medical School.

Each year, the Society's Charitable, Educational and Scientific Foundation presents the honor to senior medical students from Wisconsin's two medical schools "who through scholastic excellence, extracurricular achievement and interest in medical organization show high promise of becoming a complete physician."

The Houghton Award was established in 1968 by the late John H Houghton, a Wisconsin Dells general practitioner, to emphasize high ideals for future physicians. Later, his brother William J Houghton, a Milwaukee surgeon, added to the fund.

Jose Luna accepted the award, consisting of a check for $100 and a plaque, March 27 during the first session of the House of Delegates in Milwaukee. Ms Neumann was unable to personally accept her award since she is currently doing elective studies in Nepal.

Both Luna and Neumann have demonstrated outstanding leadership qualities to qualify them for this award.

A native of El Paso, Texas, Luna received his bachelor of arts degree from the University of Texas, El Paso. Upon his graduation this spring from medical school, he plans a residency in family medicine and practice.

Luna has been extremely active in a wide variety of activities directed at helping Latino students. He was one of the founders of a Milwaukee chapter of LaRama, an organization which helps Latino students pursue medical and health careers, and served as chairperson of that organization from 1977-1978.

Active in a number of medical school and community activities, Luna has served as coordinator and instructor in the Medical College of Wisconsin's Summer Bridging Program, a program to aid incoming minority students. He has also served as volunteer at the Southside Community Health Clinic in Milwaukee.

Lori Neumann is a Milwaukee native and received her undergraduate degree from Carroll College where she participated in a program to teach volunteers to serve as medical technicians in rural clinics.

Throughout her four years at the UW Medical School, Neumann has been involved in a number of medical school committees. She has served on the Executive Committee of the Family Practice Club, the Educational Policy Council, the Second Year Committee and the Clinical Years Committee. During her senior year she was elected to Alpha Omega Alpha.

She plans a residency training program in family medicine and practice and last summer served a family practice externship.

•**Late Resolution E,** introduced by President-elect Lewis at the request of the Wood County Medical Society, **requests that the Council thoroughly review health licensing statutes** and provide model legislation for physicians and allied health professionals to follow in shared practice settings. The reference committee recommends adoption of this resolution.

Action: Adopted as follows (whereases omitted)

RESOLVED, That the Council of the State Medical Society of Wisconsin be directed to 1) review the present medical practice act and statutes, and 2) develop an enlightened and progressive policy with appropriate guidelines for physicians and allied health professionals to follow in their shared responsibility in patient care; and be it further

RESOLVED, That the Council draft necessary model legislation as deemed indicated from their deliberations in order to facilitate the necessary changes in the practice act and statutes; and be it further

RESOLVED, That the Council report its deliberations to the membership of the State Medical Society through the House of Delegates by the annual meeting of 1981.

•**Late Resolution G** introduced by Councilor John P Mullooly **deals with Marijuana as a Dangerous Drug.** The reference committee recommends adoption, deleting the words "and unequivocally" in the first resolve.

Action: Adopted as follows (whereases omitted)

RESOLVED, That the State Medical Society of Wisconsin officially declare Marijuana to be a dangerous drug; and be it further

RESOLVED, That the State Medical Society urge the American Medical Association to take similar action when the AMA House of Delegates convenes in July, 1980.

REFERENCE COMMITTEE ON FINANCES

•**Resolution 4, SMS Dues for Spouse Physicians.** There was discussion by various members, including a representative from the Dane County Medical Society which introduced the resolution. This committee feels that while the idea may have some merit in the future, it is unworkable at the present time. In addition, we know of no general income discrepancy between physician husband and wife that would justify dues relief, and recommend rejection of Resolution 4.

Action: Resolution rejected

•**Treasurer's Report and Audit Report.** The report of the Society's Treasurer, Richard W Edwards, MD, and the audit report by the Society's independent certified public accounting firm were received. There was considerable discussion of the content. The committee expresses concern regarding what could appear to be reporting methods by the independent CPA which may suggest inappropriate expense against net income for the year 1979. (This relates to inclusion of the 1979 operating loss of SMS Services, Inc, on the SMS Statement of Income and Expense for 1979 and is explained in a footnote to the audit report on file at the Society.) The committee recommends these reports be received.

Action: Received (See SMS General Fund financial statements elsewhere in this issue.)

•**1980 Budget and Related Comments In Council Report T.** We heard testimony from the Society's Treasurer and members of the Council's Finance Committee as well as others. The committee notes that continued efforts have been expended to apply an appropriate amount of dues to reserves and recommends this be continued, and that the 1980 budget be adopted as presented.

Action: Adopted

•**Council Report T Regarding Regular and Resident Dues for 1981.** The committee concurs with the recommendation of the Council's Finance Committee to continue the May 1979 House of Delegates direction of using the CPI as a factor in determining future years' dues. The committee therefore recommends that regular member dues for 1981 be increased 10.1% or $35, to $380. In addition, the committee recommends State Society dues for resident members be established at $15 for 1981.

Action: Adopted

•**Report N, Jail Health.** After hearing testimony and reviewing the report, the reference committee wishes to commend the Jail Health Committee and others who are involved for their diligent efforts to this worthwhile project, and recommend adoption of Report N.

Action: Adopted

•**Report S, Wisconsin Medical Journal.** We took note of this report and wish to commend the Editorial Board for its efforts in maintaining high standards particularly in the editorial sections. The report includes a recommendation to the effect that a membership list be published in the *Wisconsin Medical Journal* as soon as practical and appropriate. The reference committee recommends appropriate staff study be carried out to accomplish this in a format that is deemed most appropriate (adopted) and that Report S be adopted as a whole.

Action: Adopted

•Informational Report of SMS Services, Inc. We have taken note of the escalation of member benefits that are available since SMS Services was established in 1978. We encourage members to review the Medigram and other publications of the Society for future announcements on benefit changes and additions. The committee recommends this report be received.

Action: Received

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

•Report of the President. The committee recommends adoption and encourages implementation of President Treffert's recommendations for future activity by the Society. It applauds the work of Doctor Treffert during his tenure as president and expresses its appreciation to him for the outstanding leadership over the past year.

Action: Report adopted (and printed elsewhere in this issue)

•Report of President-elect. The committee recommends adoption of the report of Doctor Lewis.

Action: Adopted (and printed elsewhere in this issue)

•Resolution 5 recommends that the 1981 State Medical Society annual meeting be held at Telemark and that every fifth annual meeting be held in the northern part of the state. The Society's annual meetings are usually held in Milwaukee because it provides the best facilities and offers greatest opportunity for good attendance by physicians and participation of exhibitors necessary for proper funding of the annual meeting. The committee supports the recommendation of the Commission on Continuing Medical Education and the Council that the annual meetings through 1992 be held in Milwaukee. The committee, therefore, recommends that Resolution 5 be rejected, but that the Commission on Continuing Medical Education should continue to evaluate alternative annual meeting sites that would offer adequate facilities and encourage appropriate attendance.

Action: Resolution rejected

•Resolution 6 opposes any requirement that physicians take a license exam after a certain age. The Medical Examining Board has established a committee chaired by Doctor Treffert to examine issues relating to the competency of physicians including the issue of compulsory relicensure of older physicians. The committee believes that age alone should not be a reason for compulsory relicensure and recommends adoption of Resolution 6.

Action: Adopted

•Resolution 7 opposes mandatory continuing medical education and urges that the Medical Examining Board evaluate alternative methods of assuring competency of physicians. The committee believes that continuing medical education is an essential element of medical practice and that the current statutory requirement for 30 hours of continuing medical education credit every two years is not a significant burden for Wisconsin physicians. In addition, the statutory 30 hour continuing medical education requirement was enacted by the Legislature as a part of the legislative package that established the state malpractice insurance system. The State Medical Society supported this legislative package that included the continuing medical education requirement. Therefore, the committee recommends rejection of Resolution 7.

Action: Resolution rejected

•Resolution 9 recommends "that the State Medical Society of Wisconsin serve as a catalyst bringing together teachers, judiciary, police personnel, legislators, and other interested parties into a public forum to address itself to the question of juvenile crime prevention." The committee believes that juvenile crime prevention is an appropriate issue for physician consideration and that recent efforts by the Society to promote community health programming set ample precedent for State Society involvement with issues such as this. The committee also feels that the last three whereas clauses are debatable and not germane to the thrust of the resolution. It also recommends that consideration of the juvenile crime issue be incorporated with existing community health programs planned by the Society such as the Work Week of Health or the upcoming Physicians and Schools Conference.

Action: Adopted

•Resolution 10 expresses concern with problems of dehydration and electrolyte imbalance among those who participate in competitive sports at the high school level. The committee recommends adoption with the resolve restated as follows: "RESOLVED, That the State Medical Society of Wisconsin petition the WIAA and local school boards to influence all coaches to have fluid available and encourage its use without restriction."

Action: Adopted as amended

•Ad Hoc Committee on Public Health (Report D), Ad Hoc Committee on Physician Distribution (Report E), Ad Hoc Committee on Women's Health Issues (Report F), and related comments in Council Report T and supplementary report. The final reports of the three committees are still being developed and are unavailable for consideration by the House of Delegates. The reference committee recommends adoption of their progress reports and that the final reports be sub-

mitted to the Council for approval and then communicated to the membership of the Society through the *Wisconsin Medical Journal.*

Action: Adopted

•Report G of the Commission on Mediation and Peer Review outlines the Commission's activities over the past year in mediation, peer review, impaired physician assistance, and establishment of the Medicaid Medical Audit Committee. The reference committee wishes to commend the Commission for its impressive agenda and for its success in combining the heretofore separate functions of mediation and peer review, and recommends adoption of Report G.

Action: Adopted

•Report H of the Continuing Medical Education Commission outlines the activities of the Commission in accreditation of continuing medical education programs, the continuing medical education licensure requirement, and continuing medical education programming. The committee takes special note of the recommendation for annual meeting dates in Milwaukee at the new Hyatt Regency Hotel and MECCA from 1982 through 1992. The committee recommends approval of Milwaukee's Hyatt Regency Hotel and MECCA as the site for the State Medical Society annual meeting from 1982 through 1992 and recommends adoption of Report H.

Action: Adopted

Presidential candidate John Anderson appears before SMS House of Delegates

Representative John Anderson (R-Illinois), a candidate for the Republican presidential nomination, spoke briefly to the House of Delegates during its first session March 27 in Milwaukee. A few of his remarks follow:

"The American healthcare system is basically a sound and reliable institution and it should remain a function of the private sector.

"Eighty-one million Americans are not protected against catastrophic illness. . . I would make a federally funded catastrophic health insurance program available for all.

"We must apply principles of marketplace economics to the healthcare system by encouraging competition for the federal healthcare dollar among all health insurance plans, including HMOs."

Presidential candidate John Anderson

Medical school deans given $22,023.91 by AMA-ERF

During a House session, Mrs Leslie Stone, Oshkosh, Wisconsin Auxiliary chairman for AMA-ERF, presented checks totaling $22,023.91 to the deans representing Wisconsin's two medical schools. Arnold Brown, MD, University of Wisconsin Medical School, Madison, received $10,874.57. Edward Lennon, MD, Medical College of Wisconsin, Milwaukee, received $11,149.34.

WISPAC takes third place in AMPAC sustaining membership

Third place honors for 1979 sustaining membership in AMPAC (American Medical Physicians Political Action Committee) went to WISPAC (Wisconsin Physicians Political Action Committee) March 27 during the SMS Annual Meeting in Milwaukee. AMA Trustee John J Coury Jr, MD, Port Huron, Michigan, presented the 1979 AMPAC Award to WISPAC Chairman Kenneth Viste, MD, Oshkosh, in appreciation of WISPAC's outstanding contribution to medical political action.

Doctor Viste and Doctor Coury

Doctor Russell commended for contributions to sports medicine

Doctor Russell and Doctor Flaherty

James C Russell, MD, Fort Atkinson, was presented with a special resolution from the Council of the State Medical Society March 27 in appreciation of the "vital role he has played over the years in protecting the health and well-being of Wisconsin athletes and young people and for his outstanding work in instilling the value of sports medicine in the minds of coaches, athletes and other physicians throughout the state."

Council Vice-chairman Timothy Flaherty, MD, Neenah, made the presentation to Doctor Russell during the first session of the House of Delegates at the SMS Annual Meeting in Milwaukee.

A general practitioner, Doctor Russell has been an enthusiastic supporter of high school and college athletics. For the past two decades he has served as team physician for both the University of Wisconsin Whitewater and Fort Atkinson High School.

He has served as a medical advisor to the Wisconsin Interscholastic Athletic Association (WIAA) and has been the WIAA's official physician at the state high school basketball tournaments for several years.

He has been a member of the SMS Committee on School Health for 22 years and its chairman for the past 16 years.

A respected authority on the prevention and treatment of athletic injuries, Doctor Russell has conducted numerous workshops, injury symposiums and seminars on the subject.

Last December, Doctor Russell's contributions to high school athletics were recognized by the National Association of State High School Athletic Directors when the group awarded him its Distinguished Service Award—marking the first time the association had given the award to anyone outside its membership.

Presidential Citation awarded to free clinic founder

Doctor Treffert and Doctor Czajka

John J Czajka, MD, a Milwaukee pediatrician, was honored by the State Medical Society of Wisconsin during the President's Dinner, Friday evening, March 28, for his outstanding contributions to the health of Milwaukee children through his work at the Guadalupe Children's Medical and Dental Clinic—a free clinic serving Milwaukee's southside Hispanic community.

SMS President Darold A Treffert, MD, Fond du Lac, presented Doctor Czajka with the Presidential Citation of the Society. The Presidential Citation is awarded to individuals who have made significant contributions to medicine or public health.

Ten years ago, Doctor Czajka founded the free clinic, then housed in a single room in a building at 112 South 3rd Street, in an effort to meet several specific health problems in the Hispanic community which were not adequately being met because of language, cultural and distance barriers. These health problems ranged from anemia to tooth decay.

Today, the clinic occupies an entire building and offers medical and dental care to children, and obstetrical-gynecological care to women of the Hispanic community.

Last year, the clinic serviced 13,500 patients.

The Guadalupe Clinic receives no government funds and depends on contributions from citizens and groups, as well as volunteer help from doctors, nurses, laboratory technicians, dental hygienists and other allied health personnel to maintain its operation.

Additionally, many Milwaukee-area physicians see patients referred to them by clinic physicians on a free basis in their own offices.

•Report I of the Commission on Health Planning outlines the commission's activities in assisting in drafting the 1980-83 State Health Plan, participation in the development of administrative rules for the decertification of specialized hospital service programs, the development of the Wisconsin Physicians Planning Network, and implementation of a health planning symposium on "Health Care in the 80's." The committee wishes to commend the commission for its effectiveness in dealing with the State Health Plan and the critical issues surrounding decertification, and recommends adoption of Report I.

Action: Adopted

•Report J of the Committee on School Health outlines extensive activities over the past year and a bold agenda for the coming year. The reference committee commends the committee for its programming on running injuries with Doctor George Sheehan, supports its objectives for improving health education in Wisconsin schools, and recommends adoption of the report.

Action: Adopted

•Report K of the Committee on Aging and Extended Care Facilities describes efforts under way to establish a statewide organization of medical directors of long-term care facilities. The reference committee wishes to commend the committee for initiating such an organization and promoting education programming for its members, and recommends adoption of the Report.

Action: Adopted

•Report L of the Committee on Maternal and Child Health outlines its activities regarding the maternal and child health grant allocation plan prepared by the state, the implementation of a Children's Health and Safety Conference, health education in Wisconsin schools, and International Year of the Child. The reference committee commends the committee for its activity over the past year and expresses its appreciation for the successful conference on "The Policies and Politics of Children's Health and Safety," and recommends adoption of the report.

Action: Adopted

•Report M of the Committee on Mental Health describes the extensive activity of the committee in reviewing legislative proposals on commitment standards as well as the Title 19 Super-Rule with regard to reimbursement for psychotherapy services. The reference committee commends the Committee on Mental Health for its extensive activity and supports its objective of correcting deficiencies in the state mental health law, and recommends adoption of the report.

Action: Adopted

•Report O of the Committee on Medicine and Religion explains efforts by the committee to meet with clergy to improve communication and cooperation for the benefit of patients. The reference committee strongly supports the work of this committee, particularly regarding the promotion of a continuing medical education course using the Wisconsin Educational Telephone Network, and recommends adoption of the report.

Action: Adopted

•Report U of the Secretary of the State Medical Society outlines management strategies for the implementation of the Society's goals and objectives. The committee wishes to commend the Secretary and all other SMS staff for their excellent work over the past year, and recommends adoption of the report.

Action: Adopted

•Report T of the Council relating to Private Patient Peer Review explains that the attempt by the Council to initiate an independent program of private patient peer review has not succeeded. The committee recommends adoption of the private patient peer review section of Report T by the Council.

Action: Adopted

•Supplementary Report of the Council relating to silver nitrate. The committee recommends adoption of the recommendation from the Committee on Maternal and Child Health and the Council that the State Medical Society support the use of silver nitrate, tetracycline, and erythromycin as acceptable prophylactic for the prevention of gonococcal ophthalmia neonatorum. The reference committee also recommends that the Maternal and Child Health Committee continue negotiations with the Department of Health and Social Services on the development of appropriate administrative rules on this subject which will address the issues of single versus multiple container use, strengths and types of preparations, and instillation timing.

Action: Adopted

•Late Resolution A relating to Nursing and Nursing Education, introduced by Councilor John Mullooly, MD on behalf of the District I Delegation, reconfirms the action of the Council and the House of Delegates in 1979 that supports the development of nursing education programs at all levels including degree schools, diploma schools, and schools for licensed practical nurses. The Committee recommends adoption of Resolution A.

Action: Adopted

Washington, DC physician recipient of Elvehjem Award

This year's Elvehjem Memorial Lecture Award was presented to Leonard B Seeff, MD, Head of the Section of Gastroenterology at Veterans Administration Hospital in Washington, DC, during the Internal Medicine Program on Saturday, March 29 at MECCA.

Doctor Seeff received the award from John P Mullooly, MD, Milwaukee, for his presentation on "Immunotherapy for Infectious Hepatitis."

The Charitable, Educational and Scientific Foundation established the Elvehjem Memorial Lecture in 1962 to honor the memory of Conrad A Elvehjem, PhD, the 13th president of the University of Wisconsin and an international authority in biochemistry. It is designed to perpetuate Doctor Elvehjem's contributions to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians.

Doctor Seeff and Doctor Mullooly

Doctor Elvehjem gained international prominence for his scientific work in the 1930s when he isolated nicotinic acid—leading directly to the cure for human pellagra.

Safe Transportation Committee, Doctor Weygandt saluted

The SMS Committee on Safe Transportation and its Chairman James L Weygandt, MD, Sheboygan Falls, were honored by the Department of Transportation, Division of Motor Vehicles, March 27 for their contributions to traffic safety in Wisconsin.

State Highway Safety Coordinator James Peterson presented two plaques to Doctor Weygandt, one on behalf of the work of the Committee on Safe Transportation and one to Doctor Weygandt personally for the leadership he has provided to the Committee during the past ten years.

"Over the years, Doctor James Weygandt has been a strong supporter of traffic safety, with special emphasis on the medical aspects of driving," said Peterson in presenting the award.

"In addition to his role on the Committee he has personally assisted in training programs aimed at improving the knowledge and understanding of driver examiners—to better qualify them to recognize and deal with applicants having medical problems."

The Committee on Safe Transportation of the State Medical Society was appointed by DOT Secretary Bakke in 1969 to provide medical advice to the Division of Motor Vehicles relating to the safe operation of motor vehicles and the issuance of operator's licenses.

Peterson lauded the nine member Committee and Doctor Weygandt for their efforts in several

Mr Peterson and Doctor Weygandt

traffic safety related projects including: 1) establishing medical and vision screening criteria to be applied to driver-license applicants; 2) design of medical reporting forms of the Department of Transportation's use in screening physical, mental, and vision conditions of driver license applicants; 3) developing physical standards and screening criteria for school bus drivers; 4) developing Implied Consent Guidelines.

"The Committee has been extremely helpful in establishing better communications between the Department of Transportation and the medical community," said Peterson. "With the medical profession becoming aware of the medical expertise applied and available, a more meaningful program of driver screening has evolved and has certainly improved traffic safety."

•Late Resolution C regarding Continuing Medical Education Requirements and Licensure, introduced by Councilor Paul LaBissioniere, MD on behalf of the District I Delegation, urges the Medical Examining Board to change continuing medical education reporting requirements, establish a more appropriate category of licensure for retired physicians, and improve its record keeping so that an accurate account of continuing medical education credits is maintained. The Committee recommends adoption of Resolution C.

Action: Adopted

•Late Resolution F introduced by Councilor Timothy Flaherty, MD **calls for repeal of the decertification statute.** The decertification statute was enacted along with the certificate of need law in the 1977-79 session of the Legislature. A compromise was negotiated by the State Medical Society, the Wisconsin Hospital Association, the Division of Health, and certain members of the Legislature which included replacement of a proposal for total hospital service licensure with a decertification program affecting six specialized hospital services which was eventually enacted into law with the support of the State Medical Society as a party to the compromise. Administrative rules for the certificate of need portion of the law have been promulgated. Administrative rules for the decertification program are currently being developed with the assistance of technical advisory committees that include physician representatives.

The reference committee believes that to call for repeal of the decertification statute at this time would not be a pragmatic move and may jeopardize the influence of the physician members on the technical advisory committees who are attempting to help draft the important administrative rules for the decertification program. The committee also believes that the Society was a good faith party to the legislative compromise that resulted in the current certificate of need and decertification programs and therefore it would be inappropriate to ask for repeal of the law until such time as both programs are operational and an assessment of their effectiveness is made. The reference committee recommends that Resolution F be adopted with replacement of the date "1975" with the date "1977" in the first whereas clause and with deletion of the resolved clause replacing it with the following paragraphs:

"RESOLVED, That the State Medical Society of Wisconsin through its physician members and staff carefully monitor and contribute to the development of administrative rules on decertification, assuring that the rules include the elements of quality, accessibility, capability of maintaining the service, and need as criteria for decertifying the specialized hospital services referred to in the decertification section of the statutes, and be it further

"RESOLVED, That once the decertification rules are promulgated and the program is implemented that the State Medical Society urge the legislature to evaluate the effectiveness of the decertification program and consider whether or not to continue it."

Action: Following discussion, the substitute resolves were rejected and the original resolution adopted as follows (whereases omitted):

RESOLVED, That the State Medical Society of Wisconsin favors immediate repeal of Subchapter III of Chapter 150, Wisconsin Statutes, and hereby directs its officers and staff to work to this end.

•Late Resolution H introduced by President Treffert **calls for the State Medical Society to support the concept of an experienced teacher fellowship program in school health education** that would provide stipends to prepare experienced Wisconsin teachers as master health educators (and instructional leaders at the local school district level). The resolution would also have the State Medical Society encourage the State Superintendent of Public Instruction to seek foundation and/or state government funding to support such fellowships. The reference committee recommends adoption of this resolution.

Action: Adopted

OTHER ACTIONS

•Adopted request of the Section on Public Health and Preventive Medicine that its name be changed to Section on Preventive Medicine.

•Adopted motion by Milwaukee County Delegate DeLore Williams that the House of Delegates of the State Medical Society **create an ad hoc committee to study methods of dealing with national issues,** the committee to be appointed by the Speaker of the House from members of the House of Delegates, members of the Council, members of the AMA delegation, and representatives from county society leadership, with appropriate representation of views favoring and opposing unified membership, and to report deliberations and recommendations to the members of the House of Delegates prior to the 1981 annual meeting. ■

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audit of the State Medical Society of Wisconsin (General Fund) prepared by Bailey, Calmes & Co., certified public accountants.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
General Fund

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1979

INCOME		
Membership Dues		$1,292,929.00
Income From Funds Invested		77,613.88
Annual Meeting Income		40,465.50
AMA Grant for Study of Health Care in Correctional Institutions		26,421.00
Revenue From Mailing Labels and Other Items		6,541.54
Equipment Rental Income		8,226.00
AMA Collection Fees		12,182.08
Registration Fees		7,871.50
Income Received to Support Society Projects		4,500.00
Administration Fees From Related Organizations		8,549.50
Wisconsin Medical Journal Advertising, Subscription and Reprint Income		62,063.51
TOTAL INCOME		$1,547,363.51
EXPENSES		
Payroll	$675,565.92	
Payroll Related Costs	151,700.75	
President and President Elect Travel	7,096.61	
AMA Annual Clinic and Special Meetings	12,600.00	
Conference Expense	54,129.08	
Association Dues	3,620.35	
Travel Expense	108,609.50	
Telephone Expense (Net of Reimbursed Costs)	50,424.41	
Printing and Supplies	69,508.52	
Postage	37,952.90	
Insurance—General	11,331.42	
Grants and Appropriations	18,982.74	
Cafeteria Expense (Net of Reimbursed Costs)	7,452.78	
Speakers Expense	7,898.26	
Office Services	42,865.54	
Outside Services	30,654.24	
Miscellaneous Expense	2,795.36	
Certified Public Accountant Services	11,131.00	
Legal Counsel	11,379.00	
Membership Recruitment Expense	3,725.32	
Depreciation	11,667.23	
Rent—Central Office	46,133.24	
Rent—Other	4,395.34	
Personal Property Tax	1,696.52	
Repairs and Maintenance	1,005.78	
Resource Material	5,053.42	
Journal Printing (Net of Reimbursed Costs)	52,161.17	
Journal Advertising Expense	3,238.02	
Other Journal Publication Expenses	3,119.83	
Loss on Sale of Fixed Assets	211.10	
TOTAL EXPENSES		$1,448,105.35
Excess Income Over Expense State Medical Society Operations		$ 99,258.16
Income (Loss) of SMS Services, Inc (See Note 3)		($ 71,618.08)
NET INCOME OVER EXPENSE		$ 27,640.08

EDITOR'S NOTE: Notes accompanying the foregoing statements in the original Certified Audit are not included here because of space limitations.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
General Fund

BALANCE SHEET

December 31, 1979

ASSETS		
Current Assets		
Cash		$ 237,179.66
Accounts Receivable—General		29,634.87
Due From SMS Realty Corporation		31,126.95
Due From Employees Pension Plan		1,894.93
Due From SMS Services, Inc		28,679.76
Due From Wisconsin Medical Journal Advertisers		9,209.76
Due From Other Organizations for Accrued Vacation and Payroll		11,085.16
Commercial Paper		568,281.49
U.S. Government Securities		262,057.23
Certificates of Deposit		200,000.00
Common Stock—at Cost (Market Value $11,070.00)		8,361.52
Accrued Investment Income Receivable		5,839.68
Employee Travel Advances		3,000.00
Prepaid Expenses		27,358.57
Supplies Inventory		6,357.89
Total Current Assets		$1,430,067.47
Fixed Assets		
Furniture and Equipment	$ 118,004.14	
Computer Software	6,071.00	
Subtotal	$ 124,075.14	
Less: Accumulated Depreciation	74,333.98	
Total Fixed Assets		49,741.16
Other Investments		
Investment in SMS Services, Inc (See Note 3)		78,792.41
TOTAL ASSETS		$1,558,601.04
LIABILITIES AND NET WORTH		
Current Liabilities		
Accounts Payable		$ 23,782.94
Due Charitable, Educational and Scientific Foundation Incorporated		4,361.29
Dues Held for the Section on Ophthalmology		12,904.93
Dues Payable to the American Medical Association, County Medical Societies and Related Organizations		4,010.00
Accrued Payroll Taxes and Other Payroll Deductions		3,807.71
Unapplied Membership Dues		8,406.00
Accrued Payroll and Vacation Pay		57,957.93
Retirement Plan Contribution Payable		13,521.39
Journal Advertising Commissions Payable		492.42
Accrued Property Taxes		1,763.11
Sales Tax Payable		67.62
Deferred Income:		
Prepaid Membership Dues	$1,158,509.66	
Prepaid Exhibit Rental	15,500.00	
Total Deferred Income		1,174,009.66
Total Current Liabilities		$1,305,085.00
NET WORTH		
Surplus, January 1, 1979	$ 225,875.96	
Plus 1979 General Fund Income Over Expense	99,258.16	
Subtotal	$ 325,134.12	
Less: Decrease in Value of Investment in SMS Services, Inc (See Note 3)	71,618.08	
Total Surplus December 31, 1979		253,516.04
TOTAL LIABILITIES AND NET WORTH		$1,558,601.04

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Madison, Wisconsin 53707

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of April 8, 1980

NEW MEMBERS

County Medical Society

BROWN

Bayer, Gerald K, 2590 Cherrywood Lane, Green Bay 54303 (1948, Regular, Oncology/Internal Medicine, Certified-IM)
Shivamurthy, Gowdar S, 1203 S Military Ave, Green Bay 54304 (1942, Regular, Internal Medicine, Certified)

DANE

Whiffen, John R, 2704 Marshall Court, Madison 53705 (1946, Regular, Orthopedic Surgery, Certified)

FOND DU LAC

Tangen, Lyn E, 92 East Division St, Fond du Lac 54935 (1946, Regular, General Surgery)
Wang, Hong Chu, 430 East Division St, Fond du Lac 54935 (1943, Regular, Radiology/Oncology, Certified-R)

KENOSHA

Newman, Ligaya M I, 800 55th St, Kenosha 53140 (1938, Regular, Psychiatry)
Rustia, Ricardo M, 9245 First Ave, Kenosha 53140 (1932, Regular, General Practice)

LACROSSE

Pavela, Stephen L, 2691 Hillcrest Dr, LaCrosse 54601 (1949, Regular, Internal Medicine, Certified)

MARATHON

Grim, Gerald W, 2727 Plaza Dr, Wausau 54401 (1950, Regular, Family Physician, Certified)
Nietert, William C, 113 Ross Ave, Wausau 54401 (1952, Resident, Family Physician)

MILWAUKEE

Baccus, Donald J, 2909 North 50th St, Milwaukee 53210 (1947, Resident, Obstetrics and Gynecology)
Bahal, Rajinder K, 100 15th Ave, South Milwaukee 53172 (1941, Regular, Obstetrics and Gynecology, Certified)
Bahal, Santosh K, 3237 South 16th St, Milwaukee 53215 (1944, Regular, Physician Medicine and Rehabilitation, Certified)
Cryns, Werner F, 500 North 19th St, Milwaukee 53233 (1920, Regular, Family Physician/Occupational Medicine, Certified-FP)
Klein, Morris, 330 W Silver Spring Dr, Milwaukee 53217 (1925, Regular, Internal Medicine, Certified)
Kohn, Harvey S, 500 North 19th St, Milwaukee 53233 (1943, Regular, Orthopedic Surgery, Certified)
McDaniel, William P, 13405 Burleigh Rd, Brookfield 53005 (1949, Resident, Family Physician)
Worm, George J, 7827 West Burleigh St, Milwaukee 53222 (1916, Regular, General Practice)

OUTAGAMIE

Rattray, Trevor A, 900 East Grant St, Appleton 54911 (1944, Regular, Cardiovascular Surgery/General Surgery, Certified-GS)

RACINE

LeClous, David R, 5625 Washington Ave, Racine 53401 (1945, Regular, Obstetrics and Gynecology, Certified-OBG)

CHANGE OF ADDRESS

(Does not include those within a city)

GREEN

Salanova, Vicenta, Monroe, to Army Medical Center, 12101 Colfax Ave, East, Denver, CO 80240

FOND DU LAC

Wojta, William C, Pompano Beach, FL, to 901 Meadow Lane, #14, Fond du Lac 54935

LANGLADE

Curran, William P, Boynton Beach, FL, to Rte #2, Deerbrook 54424

MILWAUKEE

Hodach, Richard J, Shorewood, to Hg/571 CSC, 600 Highland Ave, Madison 53792
Theil, George B, Milwaukee, to 116 Jefferson Square 5039 Hillsboro Rd, Nashville, TN 37215

ROCK

McNichols, Edwin F, Janesville, 3M Center Bldg 515-1, St Paul, MN 55101

WINNEBAGO

Sanzenbacher, Larry J, Oshkosh, PO Box 9058, Steamboat Spring, CO 80477
Wright, Eugene N, Oshkosh, to PO Box 300, Butte Des Morts 54927

WOOD

Supanwanid, Preecha, Marshfield, to 2411 East Jolly Rd, #10, Lansing, MI 48910
Tarabishi, M Hisham, Marshfield, to 3rd and Seminole, Mc Asester, OK 74501
Wolski, Kenneth P, Marshfield, to 760 John's Lane, Ambler, PA 19002

COUNTY-TO-COUNTY TRANSFER

Milwaukee to Walworth: Burnell, Ernest L, Rte #3, Box 85-C, Fontana 53125
Milwaukee to Waukesha: Bushkell, Lawrence L, 17030 West North Ave, Brookfield 53005
Milwaukee to Waukesha: Friedman, Robert H, 2300 North Mayfair Rd, Wauwatosa 53226
Racine to Kenosha: Gerol, A Yale, Suite 12, 3734 7th Ave, Kenosha 53140

DEATHS

Thompson, Fredric A, Waukesha County, Mar 19, 1980
King, Joseph M, Milwaukee County, Apr 3, 1980
Senty, Robert M, Sheboygan County, Apr 7, 1980 ■

Obituaries

◊ County, State, AMA Members

◊ **Addie M Schwittay, MD,** 86, Madison, died Feb 9, 1980 in Madison. Born Apr 17, 1893 in Pound, Doctor Schwittay graduated from the University of Wisconsin Medical School, Madison, in 1931. She was affiliated with the Jackson Clinic for 30 years until her retirement in 1964. Prior to becoming a physician, Doctor Schwittay was a nurse and was director of nursing at Harlem Hospital in New York and established a school for nursing at Rutgers University. After retirement she was active in the United Nations Association, serving as president of the Dane County chapter. Surviving are three sisters, Edith Sparrenberger, Madison; Elizabeth Penberthy, Florence, and Margaret Fisher, Haddon Field, NJ.

◊ **Walter O Paulson, MD,** 75, Eau Claire, died Feb 16, 1980 in Eau Claire. Born June 1, 1904 in Daleyville, Doctor Paulson graduated from the University of Wisconsin Medical School, Madison, in 1934, and was affiliated with the Midelfort Clinic for 39 years, retiring in 1974. He was a founding fellow of the American College of Obstetricians and Gynecologists. He was on the medical staff of Luther and Sacred Heart hospitals. Surviving are his widow, two daughters, Sonja Turner, Bloomsburg, Pa, and Kathy of Denver, Colo.

◊ **George E Meloy, MD,** 72, Milwaukee, died Feb 20, 1980 in Milwaukee. Born Apr 10, 1907, Doctor Meloy graduated from Marquette University School of Medicine in 1933. Doctor Meloy had been a member of the Department of Family Practice at St Joseph's Hospital, Milwaukee, since 1933. He also was a member of the medical staff of West Allis Memorial, Sacred Heart Rehabilitation, and Family hospitals. Surviving are his widow, Marguerite; two sons, Joseph, New Berlin, and Michael of California; and one daughter, Mary of Mexico.

◊ **Dale R Fossum, MD,** 42, Oshkosh, died Feb 22, 1980 in Ironwood, Mich. Born Sept 16, 1937 in Duluth, Minn, Doctor Fossum graduated from Marquette University School of Medicine in 1964. He served in the United States Army from 1964-1973 and had been in medical practice in Oshkosh since 1973. Surviving are his widow, Sharon; one son, Scott, and two daughters, Julie and Lori.

Belated death reports

The following two obituaries recently were reported to the offices of the State Medical Society of Wisconsin.

◊ **Phillip A Quilling, MD,** 73, Menomonie, died Nov 9, 1978 in Menomonie. Born Feb 3, 1905 in Menomonie, Doctor Quilling graduated from the University of Minnesota Medical School in 1930. His internship was taken at New Asbury Hospital in Minneapolis. Surviving are his widow and two children.

John G Waddell, MD, 64, Madison, died March 1979 in Arizona. Born Apr 28, 1915 in Beloit, Doctor Waddell graduated from the University of Cincinnati School of Medicine and served his internship at St Mary's Hospital, Madison. Surviving are his widow, Ruth, and six children. ■

◊ **Fredric A Thompson, MD,** 59, West Bend, died Mar 12, 1980 in St Croix, Virgin Islands. Born Aug 26, 1920 in Mt Horeb, Doctor Thompson graduated from Marquette University School of Medicine in 1944. He served his internship and residency at Columbia Hospital in Milwaukee. Surviving are three sisters, Mrs Garner (Mildred) Scullard, Canandaigua, New York; Mrs Robert (Ruth) Murray of Mankato, Minn; Mrs Harold (Gertrude) Roberts, Orlando, Fla; and one brother, Sanford Thompson of Madison, Wis. ■

CONTRIBUTIONS CES FOUNDATION MARCH 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for March 1980.

Unrestricted

Sheboygan County Medical Auxiliary; Winnebago County Medical Auxiliary; Polk County Medical Auxiliary; Jefferson County Medical Auxiliary, Grant County Medical Auxiliary; Dodge County Medical Auxiliary; Waukesha County Medical Auxiliary; Fond du Lac County Medical Auxiliary; Pierce-St Croix County Medical Auxiliary; Outagamie County Medical Auxiliary; Dane County Medical Auxiliary; Eau Claire-Dunn-Pepin County Medical Auxiliary; Jose S Agpoon, MD; SMS Members—*Voluntary Contributions*

Restricted

Anonymous—*General Scholarship Fund*
Brown County Medical Auxiliary—*Brown County Student Loan Fund*
Membership Donations—*Aesculapian Society*
CIBA-GEIGY Corporation—*Guest Speakers Fund*

Memorials

Mrs CH Crownhart—*William D James, MD (Crownhart Memorial Fund)*
Dr-Mrs Stephen D Austin—*Fred Sargent, MD; Mrs Harold Levitas (Brown County Loan Fund)*
Mrs Robert W Burns—*Mrs Vera Sterling; Mrs Kerwin (Brown County Loan Fund)*
Mr-Mrs HB Maroney, II—*Roy Marshall (Barbara Scott Maroney Memorial Fund)*
Sara Reznichek—*Mary Markvart (Cyrus Reznichek, MD Student Loan Fund)*
Mary Lou and John LaBissoniere; Barbara and Howard Brower; William P Curran, MD; Dr-Mrs CJ Picard; State Medical Society—*William D James, MD*
Mr-Mrs Earl R Thayer; Joan Pyre; Parks and Bill Reinhardt—*Roy Marshall*
Marion J Janssen—*Richard Herzfeld*
Mr-Mrs Donald B Idzik—*Joseph S Berger, Sr*
Farrell F Golden, MD—*WW Jones, MD*
State Medical Society—*Addie M Schwittay, MD; Dale R Fossum, MD; Walter O Paulson, MD; George E Meloy, MD* ■

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Terrence W Leveck, MD, Antigo, recently became associated with the General Clinic of Antigo. Doctor Leveck graduated from the University of Colorado School of Medicine and served residencies at Letterman Army Medical Center, San Francisco, and at Madigan Army Medical Center, Tacoma, Wash. He also was assistant chief and chief of general service at Ireland Army Hospital, Ft Knox, Ky. Prior to joining the General Clinic of Antigo, he had been in private practice in Corydon, Ind.

Charles M Balliet, MD,* Wausau, recently had the honor of having the athletic field at Newman High School, Wausau, named Balliet Field. Doctor Balliet graduated from Marquette University School of Medicine in 1946. He had served as team doctor for various athletic functions since the early 1960s and the honor was bestowed "to in some way thank him for his leadership, services and friendship to the many athletes and members of the Newman family he aided."

John L Herlache, MD, Sturgeon Bay, recently was inducted as a fellow in the American College of Surgeons. In addition to being named a fellow of the ACS, Doctor Herlache also was elected vice president of the Wisconsin Chapter of the American Trauma Society.

William A Corcoran Jr, MD,* Port Washington, recently joined the staff of the Medical College of Wisconsin. Doctor Corcoran had been associated with Robert Henkle, MD,* for a number of years. He is an assistant professor in the department of medicine at the Medical College and is directing general internal medicine activities in the downtown Medical Service in Milwaukee.

Walter Baumgarten Jr, MD, formerly of St Louis, Mo, recently joined the medical staff of the Door County Medical Center. Doctor Baumgarten had practiced in St Louis for 35 years and had been an instructor in clinical medicine at Washington University School of Medicine in St Louis. He also was president of the medical staff at St Luke's as well as of the St Louis Health Association and Missouri Heart Association.

G John Weir, MD,* Marshfield, recently was named a fellow of the American College of Nuclear Physicians. Doctor Weir, specialist in nuclear medicine, is a member of the medical staff of the Marshfield Clinic.

Donald M Traul, MD formerly of Akron, Ohio, has become associated with the Brodhead Clinic. Doctor Traul graduated from Ohio State University Medical School and had practiced in Ohio for 39 years. The Brodhead Clinic is a satellite of The Monroe Clinic. Doctor Traul's son, **Donald Traul, MD*** is a member of The Monroe Clinic.

Kathleen Doyle, MD, Portage, recently became associated with the Portage Clinic, Ltd. Doctor Doyle graduated from St Louis University School of Medicine and served her residency in pediatrics at Cardinal Glennon Children's Hospital in St Louis, Mo. At the present time, Doctor Doyle is dividing her medical practice in pediatrics and genetics between the Portage Clinic and the Diagnostic Evaluation Center of Wisconsin Central Colony, Madison.

Stanley E Peterson, MD, Stoughton, recently joined the medical staff at the Stoughton Community Hospital. Doctor Peterson graduated from the University of Iowa Medical School and served his internship and residency in orthopedic surgery at Northwestern University.

Richard L Buechel, MD,* Wausau orthopedic surgeon, recently spoke on the surgical use of the Kronner external fixation device at the University of Birmingham in Oswestry, England. Physicians from all over Europe attended the conference. On returning to this country, Doctor Buechel spoke on the same subject in Snowmass, Colo, and physicians from all over the United States attended. A member of the Wausau Bone and Joint Clinic, he has practiced in Wausau since 1970.

Jewel S Huebner, MD,* Oshkosh, who retired from family practice in Fond du Lac in 1973 and is now on the emergency room staff at St Agnes Hospital, recently was presented a plaque citing him for his work with the North Fond du Lac Fire Department's emergency medical system.

Bruce J Brewer, MD,* Milwaukee, was one of the featured speakers at the Twenty-fourth Annual Postgraduate Course on Fractures and Other Trauma, April 9-12, in Chicago. He presented two papers: *Injuries to the Musculotendinous Unit* and *Tear of the Rotator Cuff—A Study of Pathology.* Doctor Brewer is Professor and Chairman, Department of Orthopaedic Surgery, Medical College of Wisconsin.

Phillip M Green, MD,* Marshfield, will be a member of the faculty presenting a program on *Legal and Ethical Aspects of Treatment for the Critically and Terminally Ill Patient,* June 5-6, at the Radisson South Hotel in

Minneapolis, Minn. The program is sponsored by the American Society of Law & Medicine in cooperation with other Minnesota organizations including the Minnesota Medical Association. Doctor Green will be a commentator for the paper, *Living Wills and Natural Death Acts.* Doctor Green is a neurologist and a clinical assistant professor of neurology of the University of Wisconsin Center for Health Sciences.

Guy W Carlson, MD,* who practiced internal medicine for 57 years in Appleton, displayed his oil paintings at the American Exchange Bank West Branch in Madison from April 14 through May 12. It was not until 26 years ago when Ole Moe, a talented artist, moved to Appleton that Doctor Carlson started learning the techniques of oil painting and enjoying the companionship of painting in Ole's studio and area around Appleton and northern Wisconsin. They later took trips with their wives to vacation and paint in Arizona, the Ozarks, and Florida. While in Florida, Doctor Carlson studied with Emile Grupe, an outstanding teacher. In 1976 Doctor Carlson semi-retired and was able to spend more time painting landscapes. His love of outdoor sports, particularly duck hunting and fishing, shows in many of his works. Since Doctor Carlson and his wife, Alta, have moved to the Oakwood Village Apartments in Madison, he is able to spend several hours most days painting in the hobby room. His family and friends hope there will be many more years of creativity from this 87-year-old "Grandpa Moses." ■

KARL HAGEDORN
Gouaches and Oils

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and others

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Milwaukee, Wisconsin 53217
(Guenther Complex)

Tuesday-Saturday
10:30 a.m.-4:30 p.m.
414/963-2043

News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Hudson Memorial Hospital, Hudson, recently announced the election of officers to its medical staff. Ruben E Fermin, MD,* general surgeon, is president and Terry G Domino, MD* family practitioner, is secretary.

St Mary's Hospital, Milwaukee, recently announced the election of officers for 1980 through 1981. George Collentine Jr, MD,* Whitefish Bay, is president. Doctor Collentine also serves as the director of the St Mary's Hospital Burn Center. President-elect is William Fetherston, MD,* Fox Point, who also is the chairman of the Department of Obstetrics and Gynecology. Abdallah Melkonian, MD,* Fox Point, a general surgeon, was elected vice-president and secretary-treasurer of the medical staff.

Sacred Heart Rehabilitation Hospital in Milwaukee has selected Roy Campanella as the recipient of the 1980 Tau Award. The award will be presented to Mr Campanella at a dinner reception June 3 at the new Hyatt Regency Milwaukee. The Tau award is given annually to an individual, or group, for outstanding service and commitment to the disabled. Last year's recipient was actress Patricia Neal. Campanella, former Brooklyn Dodger catcher, was a veteran of 21 years in professional baseball. His career ended in 1958 when he was involved in an auto accident that left him a quadriplegic—paralyzed from the neck down.

University of Wisconsin Medical School and the UW Extension Department of Continuing Medical Education, April 19, offered a new student orientation program for high school seniors and college freshmen interested in careers in medicine. "The day-long session was designed to present prospective medical students with a realistic picture of what to expect in medical school and their options after graduation," said Thomas C Meyer, MD,* chairman, Department of CME. The program's agenda also featured tours of inpatient and clinic areas at the Clinical Science Center and the basic science research facilities of the Medical School. Doctor Meyer said the student orientation program was unique in that it was offered in conjunction with "Therapeutics 1980," a CME course for physicians. The course covered current therapeutic regimens for common medical problems encountered in practice. "The programs were offered concurrently to help students realize that medical education continues after graduation," said Doctor Meyer. Students were hosted by physicians attending "Therapeutics 1980."

Milwaukee County Mental Health Complex, a new 408-bed inpatient facility on the campus of the Milwaukee Regional Medical Center in Wauwatosa, was formally dedicated March 27. The new facility, costing $24 million, is the middle link between the existing outpatient Day Hospital which was built in 1968 and the Child and Adolescent Treatment Center built in 1973. The Complex's administrator is Bert W Pyle Jr. Herzl R Spiro, MD, PhD,* the Medical College of Wisconsin's professor and chairman of the Department of Psychiatry and Mental Health Sciences, is its chief professional officer. According to Mr Pyle, the Mental Health Complex provides area residents and referred patients with every possible mental health outpatient and inpatient service, including a 24-hour hotline and a mobile crisis team. Every age group, from newborns to geriatric patients, has special programs designed to meet their needs, he added. Programs are designed to work in cooperation with other campus facilities: Milwaukee County Medical Complex (hospital), Curative Rehabilitation Center, and Froedtert Memorial Lutheran Hospital. ■

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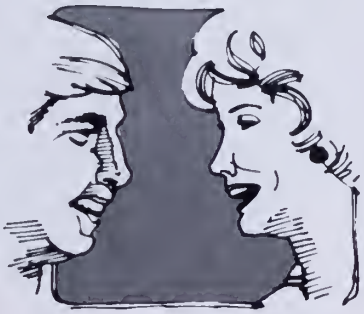
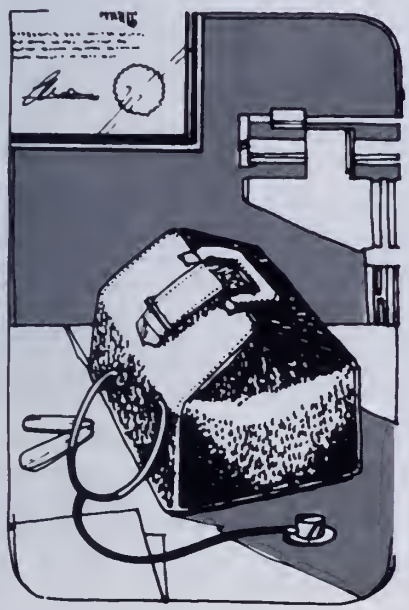
To all my patients,



Partners in Good Health



The State Medical Society of Wisconsin announces a new program designed to improve physician-patient communications and encourage greater patient feedback.

The program, entitled "Partners in Good Health," contains statement stuffers, reception area brochures, patient feedback questionaires and a certificate of participation to be displayed in the reception area.

Program brochures are available in quantity by writing to:

The Communications Department
State Medical Society of Wisconsin
P.O. Box 1109
Madison, WI 53701

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IN THE HOSPITAL

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Prepared and distributed
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Specialty Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Wisconsin Otolaryngological Society at its recent meeting elected the following officers: MDs Thomas Burrows,* Appleton, president; David M Wineinger,* Green Bay, president-elect; Charles Ford, LaCrosse, secretary-treasurer; and Robert J Toohill,* Milwaukee, membership committee chairman.

Wisconsin Society of Internal Medicine (WSIM) was named "Component Society of the Year" by the American Society of Internal Medicine (ASIM) at its 24th Annual Meeting in Washington, DC May 15-18. ASIM, a federation of 51 component societies representing 17,000 internists nationwide, is concerned with the social, economic, and political aspects of the delivery of medical care. The Wisconsin component was honored for its effectiveness during the past year in resolving member problems, increasing its visibility and influence in the state of Wisconsin, and maintaining and improving the high standards of internal medicine practice. The Wisconsin society was cited for:

- working with the state's major third party payors to identify and resolve member problems regarding concurrent care reimbursement;
- working with insurance carriers to ensure that changes in Medicare reimbursement for laboratory services were implemented appropriately, and educating members about these changes;
- introducing into the state medical society a resolution calling for equitable medical liability risk classifications;
- recognizing the importance of working with the state medical society and striving to achieve internist representation in influential positions in the state society; and
- launching an innovative personal campaign for membership recruitment. In the past year the Wisconsin society increased membership by 10 percent, and communicated with members regularly through an informative newsletter.

Current officers of the WSIM are: Michael J Mally, MD,* Hartford, president; Kenneth I Gold, MD,* Beloit, president-elect; and Joseph J Mazza, MD,* Marshfield, secretary-treasurer.

American College of Cardiology, through its Wisconsin Governor, William C Boake, MD of Madison, announced that the following cardiovascular specialists in this geographic area have achieved the ACC's membership rank of Fellowship: George F D'Cunha, MB, BCh,* Milwaukee; Shiraz P Dhanani, MBBS, Madison; Dharam Pal Jain, MBBS,* Milwaukee; Alfonso L Tiu, MD,* West Allis; and Wayne E Musser Jr, MD, Madison. ■

NEWS YOU CAN USE

ADVISORS AVAILABLE FOR CHAMPUS CLAIMS. The Civilian Health and Medical Program of Uniformed Services (CHAMPUS) reports that "health benefits advisors" are available at service medical facilities to answer provider and recipient questions regarding the CHAMPUS program. Health benefits advisors can help: (1) determine whether needed medical care is available from a nearby service facility or, if necessary, help locate an alternate source of care; (2) determine whether you will be required to obtain written approval in advance from CHAMPUS (preauthorization) for certain kinds of care; (3) assist patients in obtaining and completing CHAMPUS claim forms and filing claims; and (4) distribute health/medical information publications to beneficiaries.

CHEAP MONEY! Would you like to be able to borrow at a 6 percent annual interest rate? Well, if you carry your professional liability insurance through the Wisconsin Health Care Liability Insurance Plan (WHCLIP), you can do just that. WHCLIP offers an optional deferred payment plan which calls for a 60 percent down payment, an additional 20 percent in 90 days, and the final 20 percent in 180 days. The interest rate charged on the deferred payments is 6 percent per annum! There is also a $10 service charge for use of the plan. For further information contact Peter Wood at SMS headquarters in Madison: 1-800-362-9080 (in Madison area: 257-6781). ■

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ©IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information, FDA has classified indications as follows:
"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with own propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., addicts, former addicts, and other severe psychoneurotics has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resulting slowing of reaction time and impairment of judgement and coordination.
USE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.
Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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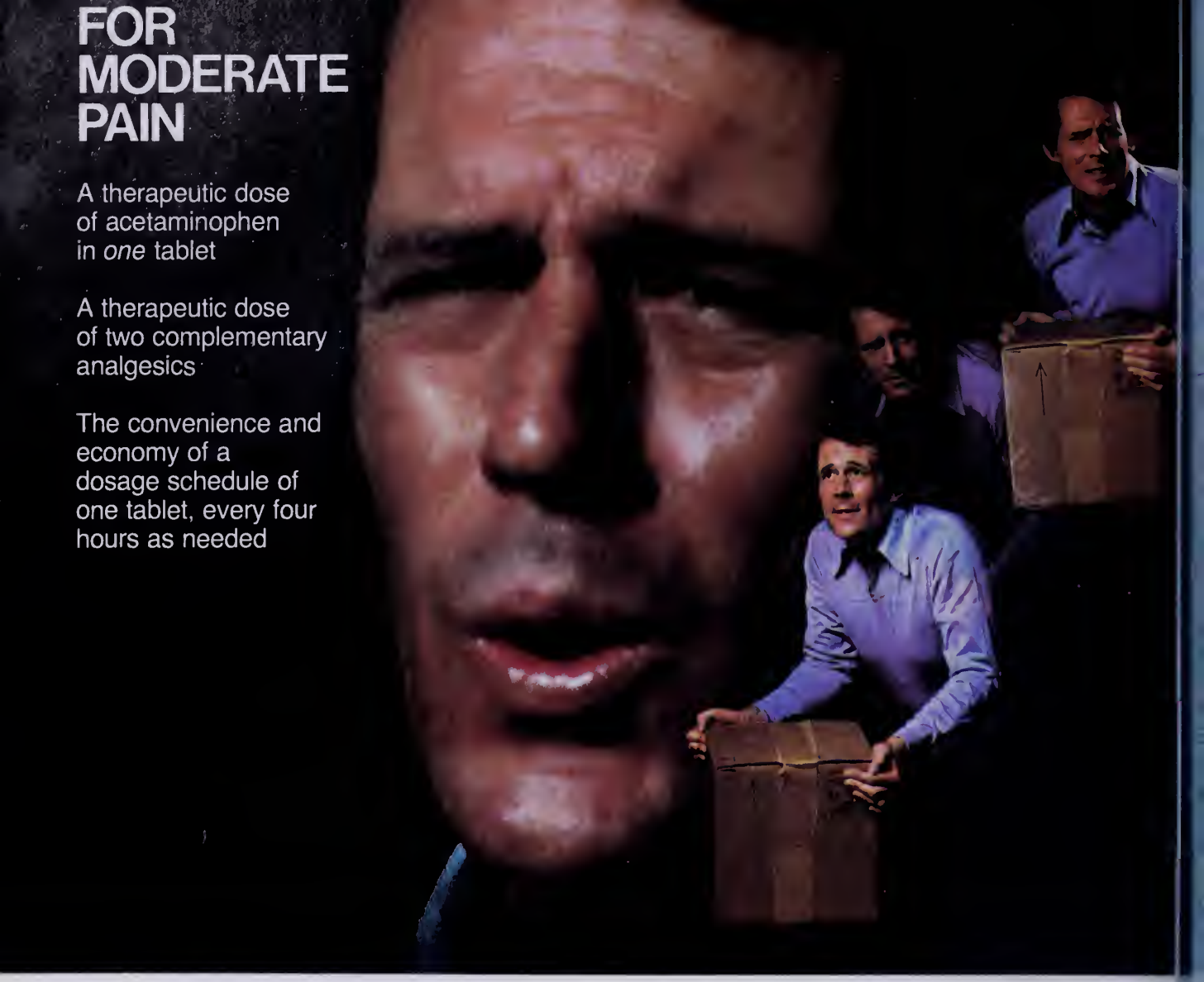
Philadelphia, Pa. 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® ©IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to those characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as local or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphen, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other suppo[illegible] tive measures should be used as indicated. Gastr[illegible] lavage may be helpful. Activated charcoal can al[illegible] sorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propox[illegible] phene alone. Acetaminophen is rapidly absorbe[illegible] and efforts to remove the drug from the body shou[illegible] not be delayed. Copious gastric lavage and/or induc[illegible] tion of emesis may be indicated. Activated charcoa[illegible] is probably ineffective unless administered almo[illegible] immediately after acetaminophen ingestion. Neith[illegible] forced diuresis nor hemodialysis appears to be a[illegible] fective in removing acetaminophen. Since acetam[illegible] nophen in overdose may have an antidiuretic effe[illegible] and may produce renal damage, administration [illegible] fluids should be carefully monitored to avoid ove[illegible] load. It has been reported that mercaptamine (cy[illegible] teamine) or other thiol compounds may protect again[illegible] liver damage if given soon after overdosage (8-[illegible] hours). N-acetylcysteine is under investigation as [illegible] less toxic alternative to mercaptamine, which ma[illegible] cause anorexia, nausea, vomiting, and drowsines[illegible] Appropriate literature should be consulted for furthe[illegible] information. (JAMA 237 2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity ma[illegible] be delayed up to one week. Acetaminophen plasm[illegible] levels and half-life may be useful in assessing th[illegible] likelihood of hepatotoxicity. Serial hepatic enzym[illegible] determinations are also recommended.

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Wyeth Laboratories
Philadelphia, Pa. 19101

WPS

report

for Wisconsin Physicians

Volume IX, Number 3 May, 1980

MEDICARE SECOND OPINION PROGRAM

WPS, as the Medicare Part B carrier in Wisconsin was requested to participate in the Second Opinion Program instituted by the Health Care Financing Administration (HCFA), a branch of the U.S. Department of Health, Education, and Welfare (HEW). Through the program, Medicare beneficiaries and others are encouraged to obtain another physician's opinion when non-emergency surgery is suggested by the patient's original physician.

Under Medicare, payment may be provided for history, examination and other covered diagnostic services required for the physician to evaluate the patient's condition and render a professional opinion on surgical necessity. Reimbursement is based on the Medicare reasonable charge determination for consultations and related services, subject to the annual $60 deductible and 20% coinsurance provisions.

WPS has two major responsibilities under the Second Opinion Program. First, WPS prepares and updates a listing of all Wisconsin physicians who have expressed a willingness to participate in the program. Second, WPS provides the names of such physicians to persons requesting second opinions, with due regard to specialty and geographic location.

Currently, over 1,100 Wisconsin physicians participate in the Medicare Second Opinion Program.

WPS has attempted to publicize the availability of this program to physicians by directly contacting as many Wisconsin physicians as possible. However, because WPS was not the Medicare Part B carrier throughout the entire state until October 1, 1979, some Wisconsin physicians might not have been fully informed of this opportunity.

Therefore, WPS requests that any physician wishing to participate in this program complete the form on the reverse side of this page and mail it to:

WPS-Medicare
P.O. Box 1787
Madison, WI 53701
Attn: CPCU

Once WPS has received the form, the physician's name will be automatically added to the list of participants. Please direct any questions about this program to the above address or phone (608) 221-4711 extension 420 and ask for Mrs. Johnson.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

PLEASE CHECK ALL APPROPRIATE BOXES

I am willing to participate in the second consultation program by:

A. ☐ Providing second consultations to Medicare beneficiaries.

I will ☐ will not ☐ accept assignment. (Acceptance of assignment is not a condition for participation in this program.)

B. ☐ Providing second consultations to Medicaid recipients.

I am certified for Medicaid ☐ Yes ☐ No

C. ☐ Providing second consultations to non-Federal patients.

D. ☐ I do not wish to participate.

Name _____

Address _____

_____

I am affiliated with the _____ clinic, group or partnership.

Phone _____

My Specialty is: _____

I am Board Certified in this Speicalty ☐ Yes ☐ No.

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

The Wisconsin Veterans Home has an immediate vacancy for a staff physician. Institutional geriatric practice at 700-bed state-operated Veterans Home. Located in an excellent summer and winter recreational area, the Wisconsin Veterans Home offers a challenging medical opportunity with the additional benefits associated with small community living. We offer competitive salary (starting to $63,000); liberal fringe benefits (40% fringe); regular hours, paid malpractice insurance, and other benefits. Contact: John Peters, Personnel Manager, Wisconsin Veterans Home, King, Wis 54946. An Equal Opportunity Employer. 3-7/80

Family Practitioner. Interested in relocating? An excellent family practice setting is available in Green Bay, Wis. Individualized practices, and coverage reciprocity. New 165-bed family practice hospital under construction. Write: Physicians in Family Practice. 120 Siegler St, Green Bay, Wis 54303. Tel: 414/497-0707. 5/80

Pediatrician: Join five-doctor department and 18 physician multispecialty clinic in Appleton, Wis. Basically primary care with teaching opportunity. Excellent hospitals. Guarantee and incentive compensation. Complete benefit package. Medium size community with excellent education, cultural, recreation, and shopping opportunities. Contact David W Boardman, Medical Arts Clinic, SC, 401 North Oneida St, Appleton, Wis 54911, telephone 414/739-0171. 4-6/80

Need two (2) Family Practice Physicians for a beautiful little community—almost completely drug and crimefree, good schools, close proximity to three colleges and one University of Wisconsin unit, good shopping, many cultural activities. Higher than usual compensation, early corporate inclusion, many fringe benefits. Well equipped 53-bed hospital, 60-bed nursing home, clinic, all under one roof. Regular consultative rounds by specialists from Madison and Dubuque. Active CME program. Five in group at present, average more than 15 years with group. Please contact: Dr M Stone, Cuba City Doctors Clinic, SC, Cuba City, Wis 53807. Phone: 608/744-2115. 5-7/80

Gonzalez Medical Center is seeking an Obstetrician/Gynecologist who is fluent in Spanish to join an established and successful practice. Minimum income guaranteed. Contact R Gonzalez, MD, 414/344-1120; 414/671-5410; and 414/476-8624. 5-7/80

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Ideal practice opportunities. 50-man multispecialty group with openings for:

- 1-2 Orthopedic Surgeons
- Urologist
- Psychiatrist
- Family Practice
- Neurosurgeon

Prestigious medical group. Perfect location for good family living, 45 minutes from Madison and 90 minutes from Milwaukee. For details contact Robert E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 (Phone collect: 608/328-7000). 3-7/80

Gynecologist needed for a primary care group of 10 physicians in northwestern Wisconsin. New 75-bed hospital. New clinic. Lester A Thompson, MD, 1020 Lakeshore Drive, Rice Lake, Wis 54868. Phone: 715/234-9031. 4-6/80

Three Year Approved Psychiatric Residency Program now appointing for an immediate unexpected opening and for July 1980. Small intensive psychiatric hospital, JCAH approved, affiliated with University of Iowa Medical College. Comprehensive program including two adult psychiatric units, adolescent unit, children's unit, alcohol and drug abuse unit, with innovative community liaison, and OPD. Eclectic approach. Situated in picturesque northeast Iowa near large cities with cultural advantages, but in rural setting. Ideal for family living. No financial sacrifice while learning. Top salary: first year $24,669, second year $25,854, third year $27,123; liberal fringe benefits; some housing available. Opportunity to join staff upon completion of training. All applicants must have completed one year in an approved training program in internal medicine, family practice, or pediatrics or a flexible one-year program, including four months in internal medicine. Write or call R M Akbar, MD, Acting Superintendent, or B J Dave, MD, Director of Education, Mental Health Institute, Independence, Iowa 50644. An Equal Opportunity Employer. 5-6/80

Physicians Exchange

continued

Multispecialty Group of 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Dermatologist
- Ophthalmologist
- Family Practitioner
- Psychiatrist

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. No personal investment. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

ENT—Orthopedic Surgeon needed for a primary care group of 10 physicians in northwestern Wisconsin. New 75-bed hospital. New clinic. Lloyd R Cotts, MD, 1020 Lakeshore Drive, Rice Lake, Wis 54868. Phone: 715/234-9031. 4-6/80

Two Family Physicians needed to staff branch clinics in two communities of 800—1300 people. Full association with 19-doctor multispecialty group, practice coverage and salary guarantees. New regional hospital serving five-county area. Residential location flexible. Outstanding family living environment. Contact: Administrator, Fort Dodge Medical Center, PC, Fort Doge, Iowa 50501. Phone: 515/573-4141. p4-5/80

Internist—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

Primary care internists and family practitioners wanted, board certified or eligible, for full-time positions in teaching hospital and medical school affiliated ambulatory care centers. Located in Milwaukee's inner city. Faculty appointments in the Medical College of Wisconsin available. Salary commensurate with qualifications and experience, plus good fringe benefits. Wisconsin licensure required. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 W Wisconsin Ave, Milwaukee, Wis 53233. Tel: 414/289-5910. 1-6/80

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN

MEDICAL PROFESSIONAL PLACEMENTS

5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency 9tfn/79

Wanted. Board Certified or Eligible OB/GYN; immediate opening with 8 physicians; multispecialty group of 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon. Clinic building is next to community hospital; expanding service area in western Milwaukee metro fringe location; first-year salary with optional second-year corporate stockholder; excellent fringe benefits including pension and profit-sharing plans. Contact J L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone 414/673-5745 collect. 5tfn/80

The Nicolet Clinic, SC a progressive 33-physician multispecialty group is looking for physicians in the following areas of practice:

- Pediatrics
- Dermatology
- Nephrology
- Family Practice

Modern, state of the art facilities, adjacent to Theda Clark Regional Medical Center and another building located on the Fox River. First-year salary open; full membership after one year. Liberal benefits including qualified Profit-Sharing Plan, and emphasis upon continued education. Outstanding professional and personal life-style opportunities. Excellent recreational area, located on the north end of Lake Winnebago. For more information, send letter and resume in confidence to E E Wilson, MD, Chairman, Recruiting Committee, or D J Anderson, FACMGA, Admin, Nicolet Clinic, SC 411 Lincoln St, Neenah, Wis 54956, or call 414/725-7071. 12/79,1-5/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Emergency Service Physicians needed for emergency service in a 125-bed hospital along the shores of Green Bay. Excellent recreational activities. Salary $60,000+, malpractice paid, other benefits. Looking to start small ER cooperation with unique time off and vacation periods. Write or call: Tom Mack, MD, 1312 16th St, Menominee, Mich 49858 or Robert Cegelski, Admin, Marinette General Hospital, 3100 Shore Drive, Marinette, Wis 54143. Phone: 715/735-6621. p5-6/80

Family Physician—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

Wanted: General Surgeon needed to join group of three Board Certified Family Practitioners. Present surgeon in group retiring after 24 years of excellent established practice. Cumberland is a lovely city of 2000 surrounded by lakes. Six-man clinic adjacent to remodeled 47-bed hospital and new surgical suite. Minneapolis, St. Paul, and Eau Claire each 80 miles away. Contract negotiable. Corporate member in one year. Contact D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 5-7/80

General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

Wanted—Family Physician to associate with four family physicians and two general surgeons to work in a satellite clinic with another family physician. 12 miles from Fond du Lac, Wisconsin, a community of 37,000 located on Lake Winnebago in the heart of Wisconsin's agricultural and recreational area. 60 miles from Milwaukee, Green Bay, Madison. Rotation of night and week-end call with four family physicians. 300-bed hospital. Excellent schools, four-year liberal arts college, two-year University of Wisconsin extension. Contact: John U Peters, MD, 505 East Division St, Fond du Lac, Wis 54935. Call collect 414/922-3700 (business) or 414/922-7899 (home). 4-7/80

Fifty-physician multispecialty clinic in west-central Wisconsin wants allergist and family practitioner to do acute medicine. Also family practice openings in nearby satellite offices. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact G E Owen, MD, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5222. 2-5/80

PEDIATRICIAN—To join 5-man department in a multispecialty clinic, practicing general and consultative pediatrics. Northeastern Wisconsin community of 50,000 with referral base 100,000; excellent medical facilities; referral Intensive Care Nursery; progressive lakeside community Contact G D Reilly, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Tel: 414/725-7071. 2-7/80

Cardiologist, Urologist, Otolaryngologist needed by 19-doctor multispecialty group in North Central Iowa. New clinic and hospital facilities. Community of 32,000, service area of 80,000. First-year salary guarantee plus incentive. All corporate fringe benefits. Excellent schools, college, and recreational activities. Contact: Administrator, Fort Dodge Medical Center, PC, Fort Dodge, Iowa 50501. Phone: 515/573-4141. p4-5/80

Medical Emergency Service Associates (MESA), SC has immediate openings for qualified Emergency Physicians in a northwest area close to Chicago which is an ideal setting in a new progressive hospital. The community offers an excellent school system and many community activities. It is a short distance from all of the cultural offerings in Chicago, as well as driving distance to water sports, hunting, fishing, and many winter activities. This is a perfect opportunity for a physician and his family. MESA offers salary computed up to $84,000 annually, excellent working conditions, flexible scheduling and fringe benefits, plus the opportunity to join a stable, growing corporation dedicated to providing quality emergency medical services. Send your CV or telephone: MESA, 188 Industrial Drive, Suite 316, Elmhurst, Ill 60126; Miss Barten, telephone 312/832-4504. MESA would like to be a part of your future. 4-6/80

Surgeon-General/Vascular, noncardiac chest. Position available with a 16-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, hospital, educational, civic advantages. Please call collect or write: B J Stoehr, MD or W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Phone: 414/494-5611. 4-7/80

Family practice physician wanted to join eight family practitioners and one general surgeon in the heart of excellent fishing country. Multispecialty group affiliation. For additional information, please contact: J P Fogarty, MD, Barron, Wis 54812. Tel: 715/537-3166. 5tfn/79

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: Genefal Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Wanted General Psychiatrist. Private practice. Northern Wisconsin community. Central Northwest Psychiatric Clinic. Contact J M Tobin, MD, 2712 Stein Blvd, Eau Claire, Wis 54701. Phone: 715/834-2751. 4-6/80

Experienced General Surgeon needed to join two general internists, a gastroenterologist, three family practitioners and a pediatrician in a busy satellite of the Marshfield Clinic at Ladysmith, Wisconsin. Send curriculum vitae to Sidney E Johnson, MD, Medical Director, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449, or call collect at 715/387-5253. p4-5/80

Family practice, OB-GYN, pediatric and internal medicine positions available with a 16-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 2-5/80

General Practitioner and General Practitioner with surgery urgently needed to serve Northwestern North Dakota community with service area of 7000 population. Recent 25-bed hospital, excellent three man clinic. Good schools, no crime, great hunting and fishing. May work for salary or lease with option to purchase clinic. Call collect 701/965-6384, Sister Juliana Schwab, Admin, St Luke's Hospital, Crosby, ND 58730. 5-6/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Neurologists: Board eligible or certified neurologists sought for practice with busy neurosurgical group. Prefer experience with EEG and EMG. Excellent starting salary and fringe benefits. Contact Dept 472 in care of the Journal. 11tfn/79

Wanted: Primary Care physicians interested in full or half-time employment with the Department of Health and Social Services. Division of Health. Assisted by excellent nursing staff, these physicians will render quality health care to adults and juvenile residents of Wisconsin Correctional institutions located throughout the state. Current full-time opening at Waupun Correctional Institution and a half-time vacancy at Kettle Moraine Correctional Institution, Plymouth. Excellent salary and fringe benefits. Malpractice insurance paid. For more information, contact Barbara Whitemore, RN, 110 East Main St, Room 608, Madison, Wis 53703, or call 608/267/7170. An Equal Opportunity Employer Functioning Under an Affirmative Action Plan. 4-5/80

Medical Facilities

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

For Sale: Family Physician Practice. Retiring because of illness. Office in west suburban Des Moines in expanding population area. Good access to hospitals and I-routes. Office new in 1971. Some of the equipment newer. All in excellent order. Includes x-ray, Ritter table, all necessary lab equipment. Two exam rooms with pelvic tables, one peds room, one emergency room. Also usual waiting room, business office, lab, physician's office. All at ground level in center of other commercial offices. Abundant parking. Family practice from infants to elderly with established referral patterns. Medical supplies on hand to begin practice immediately. Top rate income potential. Contact Gordon Allen, 5835 Grand Ave, Suite 202, Des Moines, Iowa 50312. Phone 515/274-3581, Attorney for seller. p5/80

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Office for rent. 926 Milwaukee Ave, South Milwaukee, Wis. Any portion or entire 2nd floor available. 600 to 3600 sq ft. Will divide and remodel to suit. Immediate occupancy. Phone: 414/545-2152. 4-5/80

For Sale, Equipment for three examining rooms, two adult, one pediatric. Optical examining table and complete laboratory. Three revolving files, six, five and two stack. Treatment cabinet, diathermy sterilizers, operating room light, waiting room furniture. All like new, best offer accepted. Contact: John J Rouse, MD, 710 Webb Ave, Reedsburg, Wis 53959. Phone: 608/524-3486. p5/80

For Sale. Office and professional equipment for ophthalmology plus full equipment for otolaryngology. Am retiring. Phone 414/733-5162, residence PO Box 201, Menasha, Wis. (Phone 414/722-0806 after 4:00 pm and oblige). 5/80

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Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

WISCONSIN—1980

JUNE 11-14: *Cardiac Rehabilitation: Critical Issues and Practical Concerns,* Red Carpet Inn, Milwaukee. Eligible for AMA Category I credit; UW-Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

Jun 12-13: *Neurosurgical Intensive Care Symposium,* Inn On The Park, Madison. Fee: Physician, $110; Nurse, Resident, $60, Physician/Nurse Team, $140. Info: Contact Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

JUNE 13: Special workshop on *Cancer Causation: Environmental Factors,* at the Concourse Hotel in Madison, from 8:00 to 11:30 am, during the Eastern Cooperative Group Semi-annual Meeting, June 11-14. Details appear in box elsewhere in this section.

JUNE 13-14: *SMS Services, Inc* will present a seminar for doctors on reducing personal tax liability and increasing net worth, at Olympia Resort, Oconomowoc. Watch for further details in upcoming issues.

JUNE 16-20, 23-27; JUNE 23-27, JUNE 30-JULY 4; JULY 7-11, 14-18; JULY 14-18, 21-25; OCTOBER 6-10, 13-17: Five one-two week *Cardiac Rehabilitation Workshops.* Contact: Workshop Unit-LaCrosse Exercise Program, Mitchell Hall, University of Wisconsin, LaCrosse, Wis 54601; 608/785-8686. (Endorsement by American College of Sports Medicine)

JUNE 19-20: *Symposium on the Diabetic Pregnancy and the Infant of the Diabetic Mother,* Wisconsin Center, Madison. Fee: $130. 12 credit hours of PRA-AMA Category I. AAFP prescribed credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

JUNE 23-25: Symposium on *Complications in Vascular Surgery,* cosponsored by the Division of Surgery of the Medical College of Wisconsin and the Council on Cardiovascular Surgery of the American Heart Association, at the MCW in Milwaukee.

JUNE 25-27: First Annual Madison Clinical Conference with this year's theme: *Therapeutic Advances in Infectious Disease.* Presented by Extension Services in Pharmacy in cooperation with the School of Pharmacy and the Clinical Pharmacology Section (Department of Medicine), University of Wisconsin-Madison. Conference will explore the following subject areas: (1) selected areas of infectious disease, (2) quality assurance and drug utilization review, and (3) research methods and funding sources. Program has a dual appeal to both clinical pharmacists and infectious disease physicians; attendees should benefit from the interaction provided by this interdisciplinary approach. Acceptable for 15 credit hours in Category I for the PRA-AMA. Deadline for registration is April 24. Info: Alan L Hanson, PhD, Extension Services in Pharmacy, School of Pharmacy, 425 North Charter St, Madison, Wis 53706, or call 608/262-3130.

SMS Services, Inc

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Reinhart, Boerner, Van Deuren, Norris & Rieselbach, SC
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A two-day seminar

Day One: *Personal Planning*
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Day Two: *Business Planning*
Sources of Capital—Cash Flow—Receivables

Friday and Saturday
JUNE 13 & 14

Olympia Resort & Spa
Oconomowoc

Golf—Swimming—Tennis
Bring your spouse—relax, enjoy

Seminar ends at 2:30 pm each day

Reservations may be made for both days or for either day separately.

RATES: Members—$125 (2 days), $75 (1 day); non-members—$175 (2 days), $100 (1 day).

Cancellations of seminar reservations must be received by May 31 to be refundable.

Additional information: Peter Wood, SMS Services, Inc, toll-free 800/362-9080.

WISCONSIN—1980

JUNE 26-28: Wisconsin Academy of Family Physicians Annual Scientific Assembly and Congress of Delegates, Chula Vista Resort, Wisconsin Dells, Wis. Info: WAFP, 850 Elm Grove Rd, Elm Grove, Wis 53122.

JULY 1: *Geriatric Cardiology,* at Marc Plaza in Milwaukee. Cosponsored by Wisconsin Regional Geriatric Center and Cardiovascular Program of Mount Sinai Medical Center. Featuring Robert Kennedy, MD, British cardiologist and coauthor of *Cardiology and Old Age.* Info: Albert Fisk, MD, Wisconsin Regional Geriatric Center, 2711 West Wells St, Milwaukee, Wis 53208; or phone 414/933-6769.

JULY 20-26: *Fifth Annual Wellness Promotion Strategies,* University of Wisconsin-Stevens Point. Limited enrollment. Info: WELLNESS PROMO V, Fred Leafgren, Student Life-Delzell Hall, University of Wisconsin, Stevens Point, Wis 54481. Phone 715/346-4194 or 715/346-2611.

AUGUST 25-27: *Pediatric Applications of Evoked Potentials* at The Wisconsin Center, Madison. Fee: $200. 17 hours credit Category 1 of AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

SEPTEMBER 17, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category 1 of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

OCTOBER 15, 1980: *One-Day Seminar for Family Physicians,* St Vincent Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category 1 of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

Eastern Cooperative Group
SEMI-ANNUAL MEETING

June 11-14 — Madison
Concourse Hotel

Special workshop, Friday June 13, 8:00 to 11:30 AM

CANCER CAUSATION: ENVIRONMENTAL FACTORS

Moderator: **Henry Pitot,** Director of McArdle Laboratory

Panel: **Roswell Boutwell,** Professor of Department of Oncology, University of Wisconsin; **Elizabeth C Miller,** Associate Director of McArdle Laboratory; **Elizabeth Whelan,** Executive Director, American Council of Science and Health, New York, and Research Associate at Harvard University; and **Arthur Upton,** Professor of Clinical and Environmental Medicine, New York Medical Center

(3.5 hours of Category 1 CME credit)

For information about the other sessions, call Barbara Miller (608/263-7837) at the ECOG Office, 905 University Ave, Madison, Wis 53705.

NOVEMBER 12, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category 1 of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

ILLINOIS—1980

SEPTEMBER 5-6: Illinois Congress on Continuing Medical Education, at Oak Brook Hyatt House, Oak Brook, Illinois. Theme: *Does CME improve physician performance?* This particularly urgent question is being addressed because the effectiveness of traditional CME is increasingly being questioned. In response to interest expressed by people from other states, CME planners from outside Illinois are being invited to this year's Illinois Congress. The theme of the Congress will be addressed directly by the speakers at two plenary sessions—Ronald W Richards, PhD, Director and Professor, Center for Educational Development, University of Illinois College of Medicine; and Richard M Caplan, MD, Associate Dean/CME at the University of Iowa. For additional information write or call the Illinois Council on CME at 55 East Monroe, Suite 3510, Chicago, Illinois 60603; (312) 236-6110. The Illinois Council on Continuing Medical Education was established in 1972 jointly by the Illinois State Medical Society and the state's eight medical schools and is supported primarily by contributions from ISMS members.

OCTOBER 19-24: *Annual Clinical Congress, American College of Surgeons,* Atlanta, Georgia. Info: ACS, 55 East Erie St, Chicago, Ill 60611; (312) 644-4050, ext 324.

MINNESOTA—1980

JUNE 5-6: *Legal and Ethical Aspects of Treatment for the Critically and Terminally Ill Patient,* at Radisson South Hotel, Minneapolis, Minn. Sponsored by American Society of Law & Medicine, in cooperation with the Minnesota Hospital Association, Minnesota Medical Association, and others. For physicians, attorneys, nurses, hospital administrators, ethicists, and others. Advance registration required; $110 for members of sponsoring organizations and $130 for nonmembers. Register with: American Society of Law & Medicine, 520 Commonwealth Ave, Boston, Mass 02215.

JUNE 13-14: *Laboratory Diagnosis—A Comprehensive Approach to Test Ordering and Interpretation,* Marquette Inn, Minneapolis, Minn. Sponsored by Mount Sinai Hospital, 2215 Park Ave, Minneapolis, Minn 55404. Registration fee: $100. Meets criteria for 10 credit hours in Category 1 of PRA-AMA. Approved for 10 hours, AAFP. (Phone: 612/871-3700, ext 1117, Mrs Evelyn Peterson, Medical Staff Secretary).

OTHERS—1980

JUNE 20-22: *Second Annual Trauma Symposium,* a continuing education course for physicians, at the Dutch Inn, Lake Buena Vista, Disney World, Florida. Sponsored jointly by the Committee on Trauma of the American College of Surgeons and the Region IV Committee on Trauma, ACS. Course curriculum will include such topics as: pediatric trauma, head injuries, renal failure, spinal injuries, management of the cardiovascular system, infection in trauma, chest injuries and blunt trauma. Advance registration limited to 300. Fee $175 for physicians; $75 for nurses and residents. Contact: Richard H Clark, MD, FACS, Chairman, 415 South 28th Ave, Hattiesburg, MS 39401; or the ACS Trauma Department, ACS, 55 E Erie St, Chicago, IL 60611.

JULY 20-23: Hospital Information Systems Sharing Group Summer Seminar, *Clinical Systems in Perspective: An Assessment for the '80s*, at the Lodge at Snowbird, Snowbird, Utah. Info: Jim Bailey at HISSG Office: (801) 972-6099; or 10 South Main St, Suite 331, Salt Lake City, Utah 84101 (801) 531-1717.

OCTOBER 24-26: *American Academy of Neurological and Orthopaedic Surgeons.* Contact: Michael R Rask, Program Chairman, 2320 Rancho Drive, Suite 108, Las Vegas, Nev 89102.

JULY 4-8: *First International Congress on Women and Sport.* Contact: Prof Antonio Venerando, Institute di Medicina Dello Sport, Via dei Campe Sportivi, 46, 00197 Roma, Italy.

SEPTEMBER 15-18: *American College of Emergency Physicians.* Las Vegas, Nev. Contact: Communications Group, ACEP, 3900 Capital City Blvd, Lansing, Mich 48906.

OCTOBER 19-24: *American Academy of Physical Medicine and Rehabilitation,* Washington, DC. Contact: Barry Miller, PO Box 995, Ann Arbor, Mich 48106, 313/572-3562.

OCTOBER 26-30: Annual Scientific Assembly of the American College of Chest Physicians, at the Sheraton Boston Hotel and Hynes Auditorium Convention Center, Boston, Mass. *CAT Scanning—Cardiopulmonary Disease* and *Detection, Diagnosis, and Management of Lung Cancer* are two of the six subjects to be discussed in the major symposia sessions. Full-day programs discussing such topics as occupational lung disease, critical care, perfusion technology, respiratory care, and echocardiography will be presented. Over 30 hours of credit may be obtained toward Category I of the PRA-AMA. Further info: Dale E Braddy, Director of Education, ACCP, 911 Busse Highway, Park Ridge, Ill 60068.

AMA—1980

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

JULY 20-24: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

SELECTED TOPICS IN GENERAL SURGERY—ABDOMINAL SURGERY

Sponsored by University of Wisconsin-Extension, Continuing Medical Education; University of Wisconsin-Madison, School of Medicine, Department of Surgery

September 5-6, 1980 at Wisconsin Center, Madison

The first of a planned series of annual conferences for the general surgeon. Emphasis on recent advances and controversial issues relating to the hepatobiliary system, upper and lower GI disease and management of cancer of the bowel. There will be discussion of each segment and related issues.

Fee: $115. 9 credit hours Category I of AMA. 9 University of Wisconsin-Extension CEHs.

Contact: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

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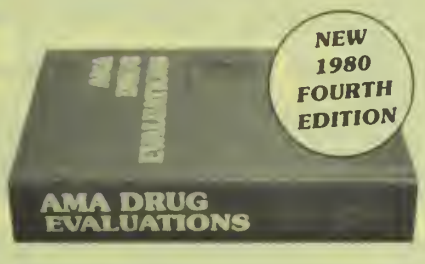
The most useful and definitive book on drug therapy!



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News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

ONE YEAR DEADLINE FOR SUBMITTING T-19 CLAIMS. A reminder to physicians that the Wisconsin Medical Assistance (Title 19) Program requires all claims to be filed within one year from the date of service. Claims filed after that time limit will be denied. Previously denied/returned claims may be refiled within 15 months of the dates of service. When refiling these claims, you must note on the claim form that the claim was previously denied or returned and the date; *eg,* "DENIED ON 12/20/79."

AMA, SMS POINT OUT MARIJUANA HEALTH HAZARDS. In a letter to Congress in April, the AMA called for improvement and expansion of programs on drug abuse and education and urged that "strong penalties and vigorous prosecution of those who traffic marijuana be maintained." The AMA made its comments in regard to a bill currently pending in Congress which would reduce federal penalties for possession of marijuana. The SMS House of Delegates took a related action in March when it approved a resolution pointing out the health hazards associated with frequent marijuana use and declared marijuana to be a dangerous drug. A recent National Institute on Drug Abuse report points out that marijuana use is increasing among younger children and that its use may be related to pulmonary damage and increased risks of cancer. Both the SMS resolution and AMA communication to Congress cited other conditions that may be encountered by those using marijuana regularly as including apathy leading to learning disabilities, delays in psychological and social maturation, emotional disorders, interference with sexual response and reproductive system, impaired functioning of cells in the brain and other organs, distortions of space and time perception and vision, and damage to the body's immune response system. For a copy of the SMS resolution, contact Joan Pyre at SMS headquarters in Madison.

NEW OPEN PERSONNEL RECORDS LAW APPLIES TO PHYSICIANS' OFFICES. A new Wisconsin law, pending the Governor's signature, provides for "open personnel records." All employers, physicians included, are required to permit the employee to inspect any personnel documents which are used or which have been used in determining that employee's qualifications for employment, promotion, transfer, additional compensation, termination or other disciplinary action, and medical records. Procedures are set up for requesting the records, for making personnel records corrections. The law states that for the medical portion of an employee's record, the employer may forward that part to the employee's physician or through a physician designated by the employee if there is reason to believe that the disclosure of an employee's medical records might have a detrimental effect on that person. (The Governor subsequently signed AB 1040 into law.)

EDS DELAYS PRE-CODING MANDATE, UNTIL JUNE 1, 1980. EDS Federal Corporation has announced that due to the difficulty many physicians and other providers have experienced in obtaining CPT-4 procedure and ICD9-CM diagnosis coding manuals, the Wisconsin Medical Assistance Program is postponing its mandate to pre-code claims until **June 1, 1980.** EDS notes that claims received on or after June 1, 1980 without ICD9-CM diagnosis codes and descriptions, regardless of dates of service, will be returned to the provider.

The CPT-4 manual can be ordered at a cost of $12.00 per copy from:

American Medical Association
Order Department OP-41
PO Box 821
Monroe, Wisconsin 53566

Copies of the ICD9-CM manual, at a cost of $49.50 for the three-volume set, may be ordered from:

American Hospital Association
Attn: Order Dept.
840 North Lakeshore Drive
Chicago, Illinois 60611 ■

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WISCONSIN MEDICAL JOURNAL

JUNE 1980

• Annual "Blue Book" issue: Presented each year since 1924 as a reference source on medicolegal, socio-economic, legislative, governmental matters of direct concern to the physician. Also a reference source on State Medical Society organizational structure, other related organizations, and state government agencies

Now, two dosage forms

Nalfon®
fenoprofen calcium

300-mg.* Pulvules® and 600-mg.* Tablets

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*Present as 345.9 mg. and 691.8 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. and 600 mg. fenoprofen respectively.

700934

NDS vol. 79 #6

LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA
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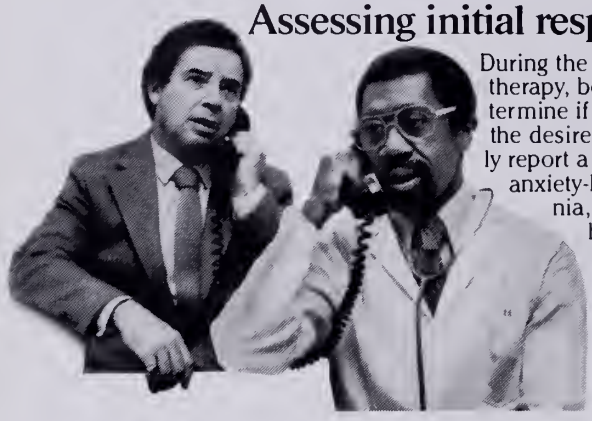
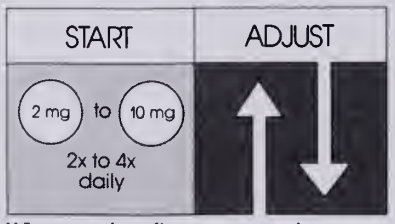
Monitoring patient response to Valium® (diazepam/Roche)



Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.

Making dosage adjustments



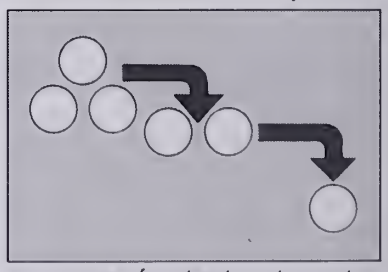
With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosa is good medical pract Although rarely necessary after short-term treatment with Valium gradual dosage reduc is advisable for patier who have been on extended therapy. This g ual discontinuance should preclude eithe recurrence of pretreatment symptoms or development of u toward side effects. Symptoms of withdrawal have almost ways been associated with abrupt discontinuance of therap higher dosages taken continuously over long periods of tim

2-mg, 5-mg, 10-mg scored tablets

Valium® (IV)

diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety

ROCHE®

See the following page for a summary of product information.

Valium®(diazepam/Roche) Ⓝ

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

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WISCONSIN MEDICAL JOURNAL

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

A Gray Area

THE MAJORITY of Americans now have some type of health insurance. This may be individual or group coverage or through Medicare, Medicaid, or some other governmental plan. However, there still are a minority in the United States who do not have such protection against the cost of serious illness, major surgery, or a long hospital stay.

This unfortunate minority cannot afford or cannot get health insurance. This may be purely a financial situation, but more often it is because of age or a preexisting condition. Many of these people are just too young for Medicare and yet too old to be considered for employment, especially with some partial disability. There is no way they can obtain coverage as individuals and usually cannot join a group.

All physicians are confronted with these situations. Many times they will waive their professional fee, but there is still the considerable cost of hospitalization.

This is a gray area, a sort of limbo in health insurance coverage. It is disastrous to be in this minority situation. Fortunately, the State Medical Society and several perceptive legislators have attempted, in the past three legislative sessions, to pass bills establishing risk-sharing "pools" to provide insurance for those considered "uninsurable" by insurance companies. However, the insurance lobby has been strong enough to defeat this badly needed protection.

There is no easy solution to the problem, but it won't go away. We should and will be hearing more about it.—VSF

The Editor's Mailbag

MOST LETTERS to the editor are published in the Journal. However, over the years there have been some gems that have been quietly filed.

One was from a prolific author in a small town who submitted unbelievable series of cases. One paper was justifiably rejected but was finally accepted by an obscure Indian medical journal. The author sent me a reprint with the message *"res ipsa loquitor"* penned across the heading.

A recent letter from a WW II WAC requested a free copy of our publication. She indicated she was very interested in medical problems and stated they had had many in the Southwest Pacific, 10,000 miles from San Francisco, California. "We had jungle rot, one WAC's feet looked like raw beef steak. It is so hard to cure. Dinghy fever causes the patient to vomit and be extremely ill and causes blindness. We had 80 cases of emphatigo, the patient is covered with sores and it is contagious. Elphantitis, the patient swells up like a balloon and is unable to feed themselves. This may require a pint of blood for some time." She also included a rather lengthy poem dedicated to a general who was retiring from service but indicated this was not for publication.

How someone in The Philippines ever got my name and the address of the medical journal is a matter of speculation. The individual wrote that she was an invalid with seven children and had extensive deformities from leprosy. She requested "a little help, even just to buy bread and milk for my little children and if you have some old, used clothing, we need it also."

Shortly before Christmas a couple of years ago I received a unique communication and probably the first in the annals of medical editors. The letter "commanded my mortal death and ordered me to eternal damnation as of 12:01 a.m. on January first." The letter further stated that I had "deliberately and willfully violated my personal honor and excreted on the sacred trust placed on me as a member of the free press." The author conveniently included his name, address, and phone number so we were able to contact the sheriff's department in his county. We learned that thirty-three others had also reported receiving similar greetings of the season. These had been addressed to all news media in Wisconsin. The letter writer originally directed his correspondence to President Carter and Vice President Mondale but had been discouraged in this regard by the Secret Service. He eventually worked his way down to the Editor of the *Wisconsin Medical Journal.* Anyway, I never heard anything further and welcomed in the New Year peacefully.

These are a few of the more memorable bits of correspondence in my almost three decades of association with the *Wisconsin Medical Journal.* — VSF ■

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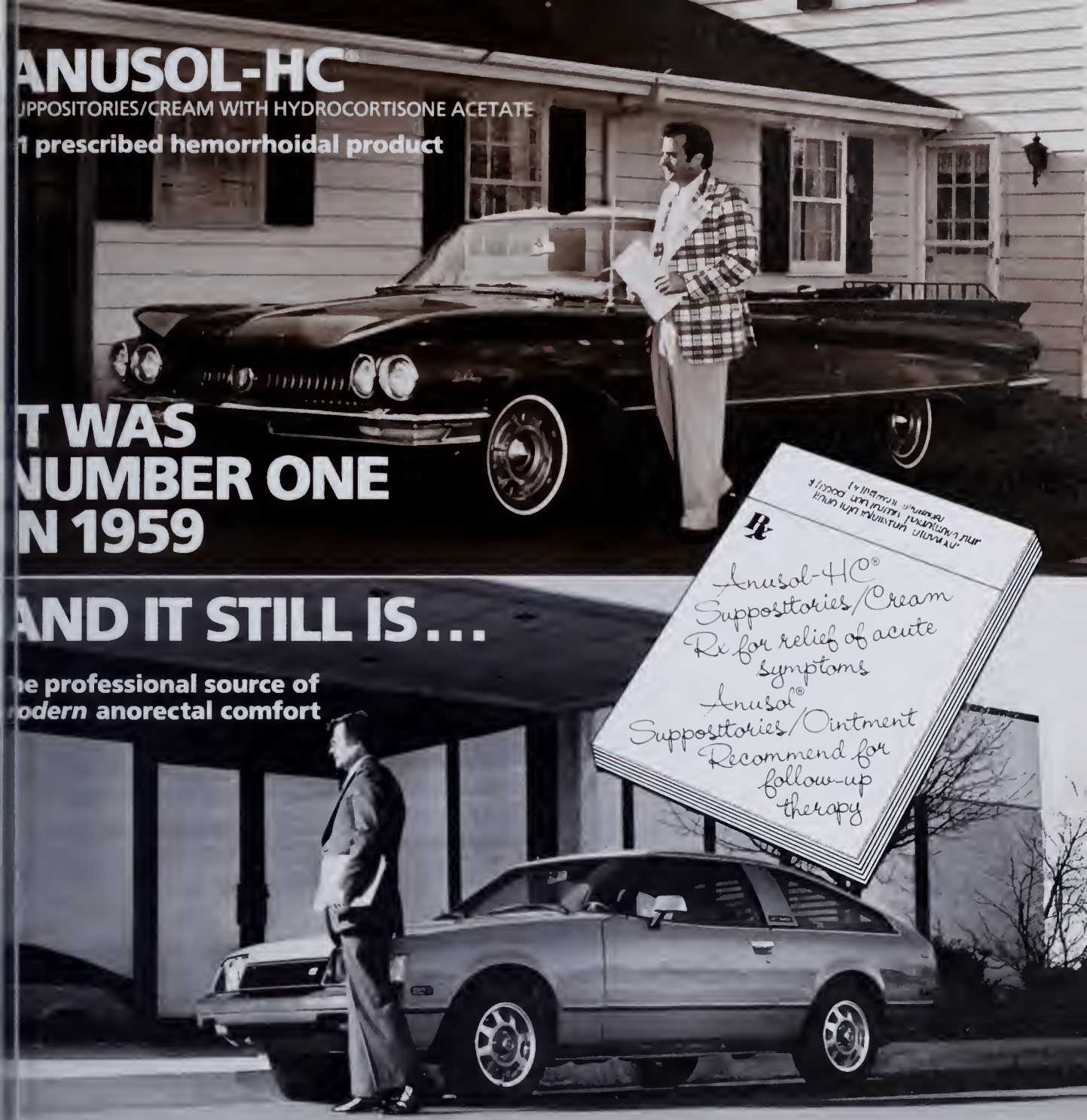

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cations: Anusol-HC Suppositories and Anusol-HC Cream adjunctive therapy for the symptomatic relief of pain and omfort in: external and internal hemorrhoids, proctitis, illitis, cryptitis, anal fissures, incomplete fistulas and relief of l pain and discomfort following anorectal surgery. nusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

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Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

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Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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Morris Plains, NJ 07950 USA

How to get health-related information in Wisconsin

THE WISCONSIN HEALTH Sciences Library Network, a network of libraries that blanket the state, stands ready to put Wisconsin health-care practitioners in touch with information in libraries throughout the country.

Any practitioner needing such information should first contact the library in his or her institution. If the person is an independent practitioner or the institution has no library, another local hospital or clinic should be contacted. Many such libraries will now serve people who are not among their primary clientele. A great number of these libraries are now organized into resource-sharing consortia and can get a needed item quickly even if they do not have it in their own collection. The libraries are also eligible to forward requests to the two Wisconsin resource libraries—in Madison (the UW Middleton Health Sciences Library) and in Milwaukee the Todd Wehr Library (Medical College of Wisconsin). The local libraries are likely to have the tools to identify which other library has the needed information.

If no local library can be found to provide these services, inquiries can be sent directly to the resource libraries at the addresses given below. Any requests that can't be filled at the state level are eligible for referral to resource libraries in the Midwest Health Science Library Network, which encompasses a six-state area, to the National Library of Medicine; and, if necessary, to the British Lending Library.

In addition to providing lending and photocopying services, the two resource libraries and many of the local libraries provide reference service. Computer searches, including MEDLINE, can now be done at the resource libraries and at Columbia, Lutheran, St Joseph's, St Luke's, St Mary's, and St Michael's hospitals in Milwaukee; Milwaukee County Medical Complex; Trinity Hospital, Cudahy; VA Hospital, Wood; St Elizabeth's Hospital, Appleton; Luther Hospital, Eau Claire; LaCrosse Lutheran Hospital; the Howard Young Medical Center, Woodruff; and St Mary's Hospital in Madison. If your local library cannot provide computer searches, it can forward any request to the most appropriate library in the network.

In most cases, the only charges will be for computer searches and for photocopies.

University of Wisconsin
Middleton Health Sciences Library
1305 Linden Drive
Madison, Wisconsin 53706
800-362-3020
Ext 2-2376

Medical College of Wisconsin
Todd Wehr Library
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Milwaukee, Wisconsin 53226
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- provides effective symptomatic relief
- *b.i.d.* dosage simplifies therapy
- scored tablet for dosage flexibility

OPTIMINE®
azatadine maleate 1 mg. tablets

CONTRAINDICATIONS Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction; symptomatic prostatic hyperitrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis

Nervous System Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

Gastrointestinal System. Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System. Urinary frequency, difficult urination, urinary retention, early menses

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils, flushing; and gastrointestinal symptoms) may also occur

If vomiting has not occurred spontaneously, the patient should be induced to vomit This is best done by having him drink a glass of water or milk after which he should be made to gag Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand Isotonic and ½ isotonic saline is the lavage solution of choice

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content

Stimulants should not be used

Vasopressors may be used to treat hypotension

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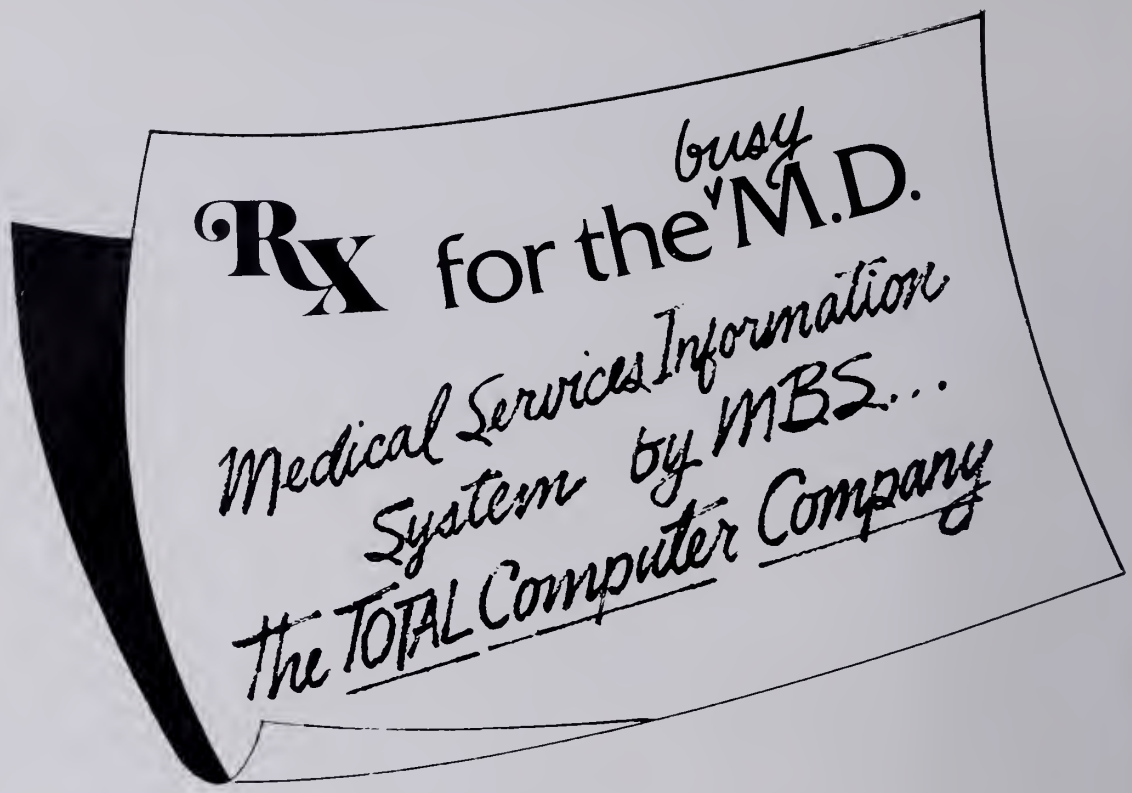

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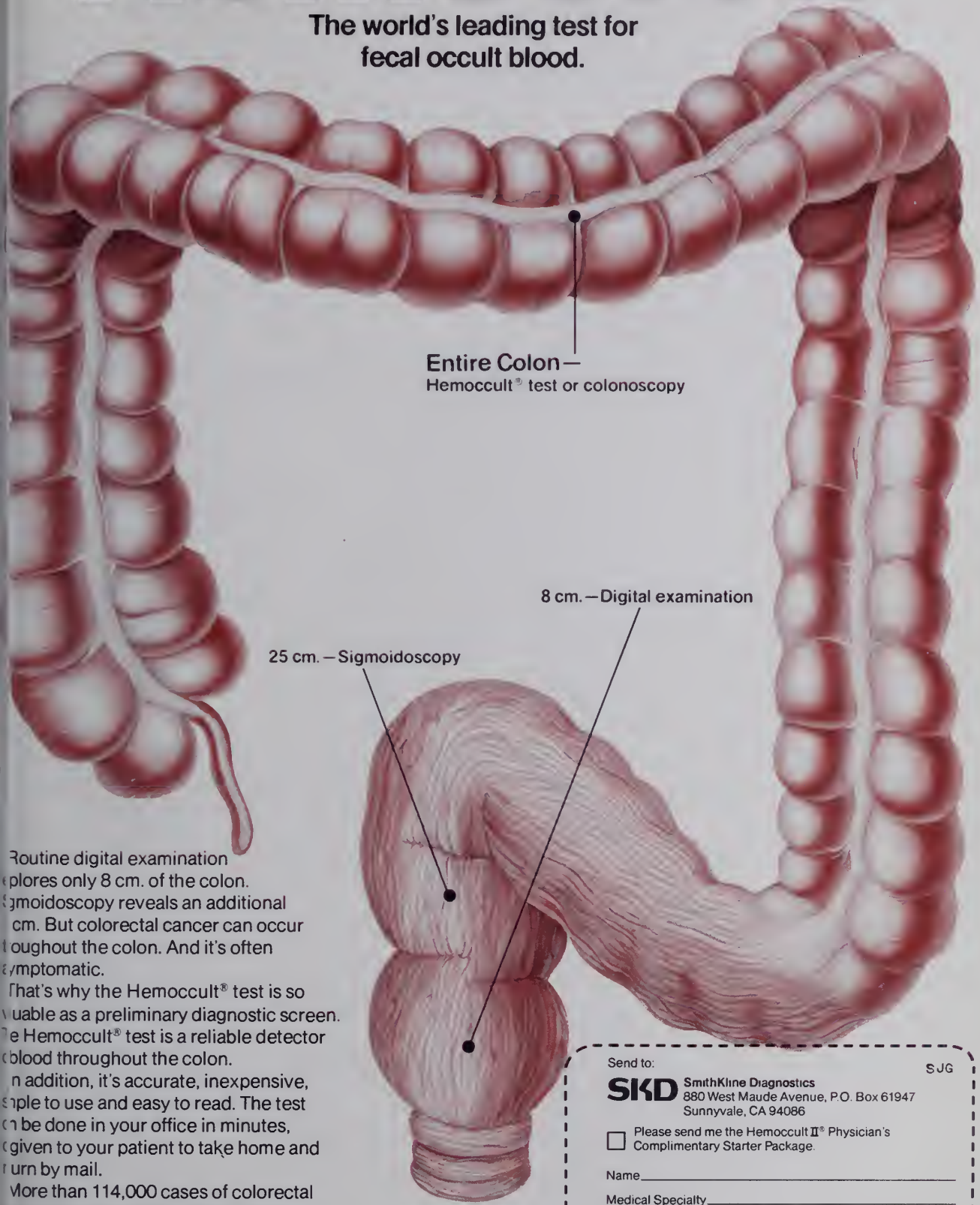

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by filling it

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physiological bulk stimulus and gentle pharmacolo
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RORER

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Bowels

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Made in West Germany
(Please see next page for prescribing information)

Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery

COMPOSITION Natural vegetable derivatives: A unique blend of psyllium and senna (Plantaga Hydrocallaid with Cassia Pod Concentrate).

INDICATION For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules. 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.

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(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information, FDA has classified the indications as follows:
"Probably" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache.
Reclassification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to persons with a history of sensitivity or severe intolerance to meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with an propensity for taking excessive quantities of drugs. Use and prolonged use in susceptible persons, e.g., addicts, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for months or months, dosage should be reduced gradually to avoid a withdrawal reaction of greater proportions than for which the drug was originally prescribed. Abrupt withdrawal of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resulting slowing of reaction time and impairment of judgement and coordination.

USE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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Philadelphia, Pa 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed

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(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other sup tive measures should be used as indicated. Ga lavage may be helpful. Activated charcoal can sorb a significant amount of ingested propoxyph phene alone. Acetaminophen is rapidly absor and efforts to remove the drug from the body sh not be delayed. Copious gastric lavage and/or in tion of emesis may be indicated. Activated char is probably ineffective unless administered si immediately after acetaminophen ingestion. Ne forced diuresis nor hemodialysis appears to b fective in removing acetaminophen. Since acet nophen in overdose may have an antidiuretic e and may produce renal damage, administratio fluids should be carefully monitored to avoid c load. It has been reported that mercaptamine teamine) or other thiol compounds may protect ag liver damage if given soon after overdosage hours). N-acetylcysteine is under investigation less toxic alternative to mercaptamine, which causa anorexia, nausea, vomiting, and drowsi Appropriate literature should be consulted for fu information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity ba delayed up to one week. Acetaminophen pl levels and half-life may be useful in assessing likelihood of hepatotoxicity. Serial hepatic en determinations are also recommended.

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Blue Book 1980

Wisconsin Medical Journal

Annual edition, since 1924, devoted to medicolegal, socioeconomic, legislative matters of direct concern to physicians in their relationships to patients, hospitals, government agencies, the Legislature, and others in the medical community.

A useful reference source throughout the year.

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Hospital liability risks not basis for usurping authority of medical staff

Donald P "Rocky" Wilcox
General Counsel, Texas Medical Association

A PRIMARY CONCERN of hospital governing boards is the risk of liability for the failure to maintain proper standards. Traditionally, hospital medical staff have had the primary duty of assuring proper medical care in the hospital. Recently some hospital governing boards have asserted that hospital liability risks for physician errors require that they dictate to medical staffs the terms and conditions of medical practice in hospitals. Such action cannot be legally justified where the medical staff has carried out its responsibility to adopt and adhere to quality care standards.

The number of disputes between hospital governing boards and organized medical staffs has been noticeable in the past few years. The basic issue in these disputes seems to center on whether or not the hospital administrator, as representative of the hospital governing board, has the legal right to dictate to its doctors the terms and conditions of their practice in the hospital. The "courts" are blamed as being the authoritative source for this position and the evidence most often cited is the Darling case *(Darling v. Charleston Community Memorial Hospital,* 211 NE 2d 253 [Ill Sup Ct., 1965]). With the Darling case as a base, "experts" assert that since the hospital is liable for the attending physician's mistakes, it must have the right to dictate to the medical staff what it believes are proper duties and responsibilities of the medical staff members. Since this is not what the Darling case stands for, a review of that case is in order.

Facts

The injured patient in Darling was an 18-year-old college student (Larry Darling) preparing for a career as a teacher-coach. As the son of the local Superintendent of Public Schools and nephew of the basketball coach for his college, he had promising career expectations.

On the first Saturday in November, he was playing defensive halfback for Eastern Illinois University and was injured during a play. After being treated by the team physician, he was sent to the emergency room of the small but JCAH-accredited Charleston Community Hospital. The only physician on emergency-room call that day was a 58-year-old general practitioner, who had not treated a major leg fracture for at least three years.

It was this physician who examined the student, had an x-ray film made, and determined that both bones below the knee in the right leg were broken. With t assistance of the nursing staff, the physician reduc the fracture and applied a plaster cast. The physici visited the student frequently while he remained in t hospital, but did not call in any specialist for consul tion.

After three weeks, the student was transferred t larger hospital and placed under the care of a we known orthopedic surgeon. The orthopedic special found a considerable amount of dead tissue in the fr tured leg, which he concluded was the result of int ference with the circulation of blood caused by the ca After several unsuccessful attempts to save the leg was amputated.

Litigation

The general practitioner and the hospital were su The physician settled the suit against him for $40,0 At the trial the issue was whether or not the hospi was liable for the boy's injuries. Evidence of prof sional negligence on the part of the physician and t nurses (the latter being clearly employees of the hos tal) was demonstrated. The hospital was held to liable in the amount of $110,000.

Analysis

This case is cited as authority for the statement t the hospital is responsible for the acts of independ private practitioners in the hospital; and, therefore, l the right to control their services. But note that Darling, the physician involved was selected and p vided by the hospital. It has been the law for ma years that when a hospital selects the physician to tr a patient, it has the obligation to act wisely in the sel tion. The hospital then, in effect, provided a physic incompetent to perform the required tasks. Furth this was not truly an emergency situation. The boy l already been seen by the team physician prior to co ing to the hospital. There was no imminent risk f death or loss of limb which compelled the gene practitioner to immediately act rather than call a ph cian competent to perform the task. Therefo although the physician may not have been an emplo of the hospital, the common law principal-agent re tionship was applied; that is, that the principal is lia for the negligent acts of his agents.

Subsequent Cases

It is interesting to note that many of the repor cases in the various states since Darling (1965) h either rejected the case as legal precedent for hold

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e hospital liable for the acts of independent practi-
ners, or have followed it as precedent for hospital
bility for physician employee negligence (principal-
ent relationship) and categorized the physician in
arling as being an employee of the hospital for liabili-
purposes.

One case rejecting Darling is *Collins* v. *Westlake ommunity Hospital* (299 NE 2d 326 [Ill App Ct, June, 73]). In that case, the patient was a young boy who is struck by an automobile. He was taken to the hos-tal where he was examined by a physician employed the hospital. The physician placed the boy's leg in oleskin traction. The boy's family physician, chosen the family, examined the boy and then referred the se to the orthopedic department chairman at the hos-tal. The orthopedist was not an employee of the spital.

The orthopedist examined the boy and reviewed the rses' notes. He replaced the moleskin traction with a ating Thomas splint. The next day, the boy's foot s cool to the touch. An elastic bandage on the boy's was loosened and warmth temporarily returned to e leg. The following evening, the orthopedist was ncerned with the boy's total loss of sensation in his t. He requested consultation by a neurosurgeon.

The following morning the nurses on duty notified e orthopedist that the boy's foot was "cold and dusky color." Two hours later the orthopedist arrived at e hospital and removed the traction. Not yet having ceived the neurosurgeon's report, he ordered imme-ate exploratory surgery. A blood clot was found in e femoral artery. A vascular specialist determined at the boy had irreversible ischemia of the leg. The llowing day, the boy's leg was amputated.

A lawsuit was filed against the hospital and the thopedist. The boy's attorney, citing Darling, imed that the hospital had a duty to review the dical care being provided him by the orthopedist. e trial court, however, ruled in favor of the hospital ing that, as a matter of law, the hospital was not ble. The issue of whether or not the orthopedist mmitted malpractice then went to the jury. After the y held in favor of the orthopedist, the boy appealed.

In affirming the decision of the trial court, the appel-e court ruled that the hospital did not have the legal ty to review the medical care provided a patient by e orthopedic surgery department chairman at the spital. It then distinguished this case from the Darl-g decision.

It characterized the physician in Darling, who was ld to have performed negligent treatment on the ient, as being "an employee of the hospital and bject to its direct supervision." The appellate court phasized that, in this case, however, the orthopedist s selected by the patient and was *not* an employee of e hospital. It was the orthopedist who was "in charge the case." Also, the court noted that the nurses were t negligent in performing their duties, whereas in rling, they were.

The following statement taken from the opinion of the appellate court summarizes the Illinois court's view of the role of the hospital in this case.

"The decision to treat a patient in the particular manner is a medical question entirely within the discretion of the treating physician, not the hospital."

Many other cases can be cited as authority for this rule of law. (See, for example, *St. John's Hospital Medical Staff* v. *St. John Regional Medical Center,* 245 NW 2d 472 [SD 1976], where unilateral action on the part of the hospital governing board to amend the medical staff bylaws, based in part on the hospital's perceived risk of liability for physician acts, was declared to be null and void.) In fact, there is not one single reported case in Texas nor in any other state in which a hospital has been held legally responsible for the negligence of an attending competent physician engaged in independent practice and selected by the patient. Thus, hospitals cannot properly use their risk of liability for physicians' mistakes to dictate to physicians terms of their professional practice in the hospital. *The rights, duties, and obligations of medical staffs and their members are negotiable.*

Quality of Care

Quality of care is a joint responsibliity. A hospital's primary objective—that of providing high quality patient care services for the community—can be achieved best if there is a close working relationship and effective cooperation between the two partners who share the responsibility for hospital operations:

(1) The board of directors or trustees responsible for the business management, housekeeping, and prudent use of the hospital's resources; and

(2) An organized staff of physicians practicing within the hospital and responsible for the methodology and implementation of the system under which the resources of the medical community are used to provide the best attainable quality of medical care and service.

The courts have not been willing to require hospital boards to assume full responsibility for the practice of medicine, but have recognized the roles of both the board and the medical staff. Medical staffs which act responsibly in assuring that proper standards of patient care and quality medical services are provided within the hospital have been supported by the courts when challenges to their traditional roles have been attempted. ■

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MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes requires that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.
i. When a physician cannot be obtained within 24 hours of death.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful. Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

13. Cancer?

Yes, to the Department of Health and Social Services.

14. Tuberculosis?

Yes, to your local Board of Health.

15. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

16. Epileptics?

No. But see article on page 68 of the June 1974 Blue Book issue.

17. Drug addiction?

No.

18. Abused or neglected children?

Yes. The law requires reports of "abused" or "neglected" (those not receiving food, clothing, shelter or care, including medical care so as to "seriously endanger" the child's health) children or those with exceptional educational needs (see article page 39). Wilful failure to report may subject a physician to a penalty; good faith reports provide immunity.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

.egal responsibilities ›f the ›hysician-patient-hospital elationship

EVERAL QUESTIONS pertaining to the physician-patient-›spital relationship were addressed by the Society's gal counsel. The questions and excerpts from the ›inion of legal counsel are presented below.

Is there a special legal responsibility of a physician to his hospitalized patient?

There are no Wisconsin statutes which directly cover · govern the question set out above. The basic statutes ı hospitals relate to construction, safety, standards of aternity departments, and licensure.

In general terms, the courts have held that a physi-an has a legal responsibility to his hospitalized patient furnish that degree of professional skill which meets e standard of professional care and to give such ·ofessional attention to the patient as the case re-ıires. A physician is not legally excused for inatten-›n to one patient on the grounds that he was occupied ith the needs of others.

A physician has a continuing responsibility to his ›spitalized patient at least to the point where the lat-r is well enough to be discharged, or sooner leaves ithout the physician's authorization. A physician may : charged with abandonment for neglecting a patient ho needs his care, whether during or after hospitaliza-›n. Once a physician has agreed to care for a par-:ular patient, he must continue to do so until the ıtient discharges him or no longer needs his profes-›nal services. He may be legally liable for neglect of e patient, or for ceasing to care for him until another ıysician has replaced him, unless he has been clearly scharged by the patient before the relieving physician ·tually takes over.

While a hospital nurse or technician may technically : in the employ of the hospital, a physician may incur gal liability for permitting a nurse or technician to rry out his treatment orders or assist him when he ıows or has reasonable cause to know that such per-n is unsuitable for such duties by reason of in-lequate training, experience, judgment or personality :fect.

The essence of negligence is the absence of the gree of care owed by one person to another. Legal bility results when negligence causes physical injury monetary damage to the object of such negligence. ıe principles of law involved are few, but their ap-ication depends upon the facts of the case, frequently evaluated by expert testimony, and as found by a ry or court.

There also has been a recent trend toward the definition and codification of social or human rights of patients apart from their right to receive care meeting the appropriate standards of professional skill. A patients' bill of rights for nursing home and residential care facility residents has been enacted both by statute and administrative rule. Several hospitals have adopted or considered such a statement of rights. While not affecting the nature of care given, this expression of patients' rights does affect the environment within which this care is provided.

2. What is the joint legal responsibility of the physician and hospital to a hospitalized patient?

The courts in the past tended to distinguish the *administrative* negligence of a hospital from the *professional or medical* negligence of a physician. The first is concerned largely with the furnishing of safe and adequate facilities, equipment, food and related services and the carrying out of such routines as bathing or other general care. The other is concerned with professional treatment or care by the physician, or the carrying out of the orders of a physician by a nursing staff, technicians or others. A hospital was liable in general for *administrative* negligence, and a physician for *professional* negligence on the part of himself or an agent, where injury results.

The distinction between the administrative and housekeeping functions for which hospitals were traditionally responsible and professional activities for which the physician was responsible has become blurred. Institutional liability for the negligence of its paraprofessional employees, frequently joint liability with independent physicians who are their immediate supervisors, is well settled. The 1965 *Darling* case in Illinois voiced a responsibility of the hospital to review and supervise the care given in the hospital. That case rested in part on the failure of hospital employees in observation and reporting but the principle established was broader. In other recent cases courts have held that hospitals may be liable for admitting incompetent practitioners to their medical staffs, for the failure of medical staffs to supervise physicians practicing in the institutions, and for not establishing quality review systems. While these all have administrative aspects, they also put the hospitals into potential jeopardy for the quality, or lack of quality, of care provided in the institution. Thus both hospital and physician *could* be liable for concurrent or related acts of negligence which united to cause damage to a patient, or where the negligent acts of the one aggravated the injuries caused by the other party.

Where joint negligence has occurred, the patient may elect to sue the hospital, the physician, or both. If the patient prevails in court against the two, he may enforce his judgment wholly against the hospital or the physician as he may prefer. If there was in fact joint liability of hospital and physician but the patient enforced his judgment against the latter, the physician

may then look to the hospital for recovery for such portion of the damages he has paid as represents the hospital's share of the total liability established by the litigation.

As a general proposition the hospital and physician have *separate* legal responsibility to the patient. The former is concerned primarily with safe and adequate facilities and the exercise of a due standard of care in the selection and supervision of its staff and to some extent the care given in the institution. The physician is concerned with the professional care which he either renders or directs on behalf of the patient. While the decisions of various courts furnish numerous instances of suits in which hospital, physician and nurse were jointly sued, it is not uncommon for a court or jury to determine during the course of the trial that no liability exists against one or more of the parties sued. In some cases only the hospital, or the physician or the nurse is found to have been liable in a particular situation. In other cases two of them may be found negligent. In still other cases the suit is dismissed as to all three.

While the functioning of the hospital as an institution and of its nurses and technical staffs with the medical staff call for a high degree of coordination, teamwork and close understanding, all for the benefit of the patient, such facts do *not* of themselves create a joint legal responsibility. Perhaps the best explanation is that while teamwork and cooperation are *practical necessities* they do not automatically create a *joint legal responsibility*. It is up to the patient who asserts negligence to declare whether the hospital, as an administrative institution or as an employer, is responsible for his injury and damage, or whether the physician or others acting under his direction were primarily responsible.

3. What is the extent of legally enforceable rights of a physician against a hospital in which he has staff privileges?

The legally enforceable rights of a physician against a hospital growing out of his staff privileges are relatively limited in character. Thus a staff physician cannot demand that certain managerial policies be adopted, for that is the function of the governing board and its administrator. He cannot demand that the hospital purchase certain equipment, but is entitled to observe that such equipment as it has is inadequate, poorly maintained or unsafe. The latter right grows out of his concern for patient interest and his professional competence to make the observations.

There are two areas worthy of comment in which a staff physician has legally enforceable rights. The first is exemplified in the so-called "inhospital staff specialties" such as radiology, pathology and physiatry. When the medical staff and the governing body of a hospital consider that it is in the public interest, it is lawful for practitioners in these specialties to contract with a hospital to provide consultation services for attending physicians. Such consultants must be members of or acceptable to the medical staff of such hospital. S long as a contract between such a specialist and hospital relating to his practice is in accordance wi the fee splitting statute and other applicable laws, it enforceable by him against the hospital and by t hospital against him.

The second area of legally enforceable rights e joyed by staff physicians are those which relate to sta privileges as such. The documents which govern sta privileges are typically bylaws, rules and regulation the application of an individual physician for sta privileges and the official action on such applicatio first, by the medical staff, and then by the governi body of the hospital. A physician whose staff appoin ment is regular in every respect acquires legally e forceable rights once he becomes a member of t medical staff. Those rights depend upon and are limit by the provisions of the hospital bylaws, rules a regulations, and by any particular conditions attach to his appointment, such as limitations on surgic privileges.

It is the proper business of the individual and colle tive membership of a medical staff to see that t granting of staff privileges, their limitation, suspensi and termination are spelled out clearly, adequately a fairly. This is a matter of proper concern to patie whom the physician may hospitalize, and of e lightened self-interest to physician and hospital as we

There appears to be a trend generally in the courts this country to recognize something akin to a prope right in hospital staff privileges *once they are grant* so long as they remain in force, and assuming that t physician is not guilty of acts of professional negligen or misconduct. This means that the trend of the cou is away from permitting summary suspension or ter nation of staff privileges without a fair hearing, exce for grave cause which might endanger patients or cre liability on the part of the hospital.

Increasing importance should be attached to "r gotiations" between the medical staff and the governi body or administrator of a hospital. These can be co ducted by the Chief of Staff of a very small hospital, by the Executive Committee of the medical staff of larger hospital, in areas in which patient welfare a safety are involved, or in which tensions or conflict m arise between hospital policy and medical policy to t detriment of patient welfare. The latter are not matt of contract right as such, but are akin to "collecti bargaining", and become a matter of understanding the point the hospital and the medical staff are agreement. They might include such areas as the willingness of the governing body of the hospital to f low medical staff recommendations for granting limiting staff privileges; failure to purchase desira or needed equipment or to replace equipment in t interests of patient safety or welfare; inadequate sel tion of the nursing, technical and other staffs of t hospital, or insufficient supervision and continu training during the course of employment. ■

The use of consent and related forms for physicians

REFACE

e forms referred to in this article are those which a ysician may have occasion to use in his regular every-y practice. Since the forms were printed in the January 70 "Blue Book" issue of the *Wisconsin Medical Jour-*, they will not be reprinted here except for a few ex-ples. Any physician wishing "sample" copies of these ms may obtain them upon request to the State Medical ciety of Wisconsin, Box 1109, Madison, Wis 53701; telephone 257-6781 in the Madison area or toll-free in sconsin 1-800-362-9080. These forms will frequently d to be adapted for a particular situation. Each phy-an should review them carefully before using them to ke sure that they reflect the realities of a specific sit-ion.

The forms, as printed in the January 1970 "Blue Book" e and as listed in the box below, and the text in this article have been prepared by legal counsel for the State Medical Society of Wisconsin, and reflect changes in the laws and courts in Wisconsin since the previous publication in January 1970.

The forms listed in the box below do not cover every possible situation where a consent should be obtained. Additional forms are contained in a publication of the American Medical Association called *Medico-legal Forms with Legal Analysis, 1976.* The Society attorneys suggest that any forms that a physician might wish to use outside of the forms referred to in this article be checked with the physician's personal attorney to determine their legal adequacy.

Finally, the forms do not cover those procedures which are normally done in a hospital. The Wisconsin Hospital Association has a publication entitled *Consent Manual.*

CONSENT FORMS FOR PHYSICIANS

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701; or tel. 608/257-6781. (Member physicians in Wisconsin may dial toll-free number: 1-800-362-9080.) Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms. These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

All member hospitals of that Association have the manual. Those forms cover hospital situations, whereas this article is concerned primarily with the physician in his regular practice.

I. What is consent

Consent, in the context that we are using it, means permission from a patient or his legal representative, to a physician to diagnose and treat the patient.

a. Informed consent

To be legally valid, consent must be given by the appropriate person (see II. *Who Can Consent,* below) and this consent must be given with appropriate understanding of the nature of the treatment and the risks associated with it. Under Wisconsin law you must disclose to the person giving consent such information as is necessary under the circumstances to enable a reasonable person under those circumstances to intelligently exercise his right to consent to or refuse treatment. The disclosure must be made in terms understandable to the person giving consent and need not include disclosure of matters already known to the person or risks which are extremely remote possibilities.

This rule leaves broad areas of professional judgment to the physician but requires disclosure of all matters that would be relevant to a reasonable person to permit him to make an intelligent decision to consent to or refuse the recommended treatment.

The forms, as printed in January 1970, and other standard forms which you may use generally do not provide for a full description of the disclosures given, either as to treatment or risks involved. You should make some provision in your patient records to indicate specifically what disclosures were made. Some physicians tape record their disclosures and retain these tapes with the patient records. Some who are involved in the same procedure frequently use prepared statements covering the treatment and its risks and obtain receipts for copies of this information. Some give disclosures in front of witnesses and have their notes on the matters disclosed initialed or countersigned by the witnesses. For your protection you should have some record of the matters disclosed in each situation.

b. Implied consent

There are situations where the consent of the patient does not have to be in writing or even expressed orally. This is implied consent.

A classic example of implied consent is the unconscious victim of an automobile accident where immediate action needs to be taken to save the life of the patient or at least to minimize the effect of his injuries. In this emergency situation consent is implied. The courts say that if the patient had been conscious he would have given consent to save his life and, therefore, the physician will not be penalized for doing what he would have been allowed to do if the patient had been conscious.

II. Who can consent

Persons who are adults and are competent to un stand what the physician is proposing to do, why necessary or desirable, and what the risks of doing it going to be, can give a consent.

a. Minors

In Wisconsin, persons under the age of 18 are minor

The proper person to consent to surgery or other t ment of a minor is either parent, or if neither pare living, the minor's court appointed guardian. A physi is not legally protected by a consent signed by a relati a minor, other than a parent, unless the relative has appointed as the minor's legal guardian by a court.

There are two exceptions to the above general r First, in an emergency, a consent is not necessary if parents or guardian cannot be located, and, in the j ment of the physician in charge and, of consultants w consultation is practical, immediate treatment is neces to save life or to prevent the deterioration or aggrava of the condition of the patient.

The legal reason for the above exception is that i emergency the law implies the consent of the patien in the case of a minor, of his parent or guardian. Bec the law does not imply consent beyond the treat actually necessary to meet an emergency, the physi may safely treat only the emergency condition itself, nothing else, without actual consent of a paren guardian.

Second, an emancipated minor can give a consent medical treatment, including surgery. A minor is ema pated (1) who is lawfully married, or (2) whose pa have divested themselves of their legal right of co over him. Typically a minor in the latter situation is who is self-supporting. An unmarried minor atten school away from his home community is not emancip by virtue of that fact alone.

A physician who has any doubt whether a min emancipated, should require the consent of a parent o legal guardian before proceeding with non-emerg treatment.

b. Incompetents

Physicians, above all others, are qualified to deten whether a person is competent to sign a consent. patient is incompetent, a consent by the patient will be any protection. For incompetents other than mi consent can only be given by the person's legally appoi guardian, except in emergencies. Courts in Wisconsin very limited powers to substitute their discretion for of a person's legally appointed guardian.

c. Persons under the influence of of drugs or intoxicants

Unless there is an emergency situation, the phys should either wait until the influence of the drug o toxicant passes, or, make appropriate contacts fo appointment of a guardian. In the case of an emerg treatment necessary to save life can be given.

| Why consents

Wisconsin failure to obtain informed consent for ical treatment is the negligent violation of a legal duty. result of this, a physician may be sued for a species ialpractice. In other states, and under earlier case law Visconsin, treatment without consent was treated as rm of assault and subject to civil, and possibly crim- liability on that basis. It is possible that in an aggra- d situation, where the physician has obtained no con- or where his treatment has gone beyond the consent n, courts would still act on the assault rather than the igence basis. In most cases, however, it should be ipated that the question will be whether informed ent was given and failure of the physician to obtain ent based on an adequate explanation of the treatment its possible risks is a form of negligent malpractice.

an action for failure of informed consent, the patient the responsibility of proving failure of disclosure by physician, lack of knowledge by the patient of the re of the treatment and its risks, and the adverse ef- of the treatment. The physician, by way of defense, prove reasons why no disclosure was given, these nses to be based on the "reasonable person" rule ssed above. No expert testimony is required to assist ury in determining whether the failure of disclosure o consent to the treatment, or phrased another way, her adequate disclosure would have resulted in the nt's refusing the treatment.

few minutes spent preparing, explaining, and ob- ng the consent signed by the patient and making ap- riate notes in the patient records can save untold s of time, money, and embarrassment for the phy- n.

Consents limited

word of caution needs to be set forth. A valid ent must not be too broad. It cannot be a general ent for the physician to do anything he wants to do. ould be limited to the specific situation presented by diagnosis of the patient's illness. Finally, a consent is effective if the treatment or procedure consented to is al, is contrary to public policy or, is given by a per- who had no legal right to give it.

Consent and related forms

e text and suggestions that follow are related to the bered forms as printed in the January 1970 "Blue k" and as listed in the box on page 23. Physicians ld read the text and suggestions prior to attempting e or adapt a particular form.

YSICIAN AND PATIENT

Contract for services

e physician-patient contract is established when the ician, in response to an express or implied request to e the patient, undertakes to render professional services to him. It is not necessary to have a formal written contract. The contract between the patient and physician is implied and is enforceable. If you wish, you may restrict your services to one procedure, one treatment or treatments at a particular time or place. This can be done by a letter requesting the patient to sign and return a copy to you. No form has been included for this situation. A physician need not accept every person who wishes services. He can accept patients as he wishes. Further, specialists need not accept patients who have illnesses outside their specialty.

However, once the patient-physician relationship has been entered into the physician is under an obligation to treat the patient until the relationship is terminated.

SUGGESTED LETTER OF WITHDRAWAL FROM CASE

THE FOLLOWING sample letter is intended for use where the patient consistently uses abusive or abrasive language to personnel, or is unruly in conduct or has a history of financial irresponsibility. It should be sent by certified mail in a *plain* envelope (one with no return address so that the patient will not refuse to accept it).

Dear Mr. (Ms.)_____
I (We) find it necessary to inform you that I (the physicians of this clinic) am (are) withdrawing from further professional attendance upon you.

This action is being taken, most reluctantly, because of your consistent failure to abide by the rules by which the operation of my practice (this clinic) is governed.

*

If you so desire, I shall be available to attend you for a reasonable time after you have received this letter, but in no event for more than five days. This should give you ample time to select another physician of your choice. With your permission and approval, I will make available to the physician you select your case history and information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

*The following optional paragraph may be inserted at this point when the patient's condition indicates that it is medically advisable:

Since your condition requires medical attention, I (we) suggest that you place yourself under the care of another physician without delay.

2. Termination of contract

Care must be taken to inform the patient appropriately, but unmistakably when the patient-physician relationship is terminated. What should be done depends upon how the situation arises.

a. Former patient

If you have a former patient who calls and wishes further services, and you do not wish to further treat that patient, you should make your decision clear. Following such conversation you should confirm it by a letter. Form 1, with its enclosure, Form 2, is appropriate and gives the physician a record for his file. (These forms appear as "examples" on page 26.)

b. Withdrawal from a case

There may be occasions where a physician does not wish to continue on a case. Consistent with legal as well as ethical principles he must find appropriate steps to withdraw. He cannot just stay away and not notify the patient. This would be abandoning the patient and could subject the physician to a suit for damages.

FORM 1

LETTER TO FORMER PATIENT WHERE PHYSICIAN DOES NOT WISH TO TREAT LATER ILLNESS

Dear _____:

This letter is to confirm our conversation of _____ _____ (date).

At that time I informed you that I could not accept you as a patient for your present illness. I suggested to you that you contact another physician and I urge you to do so now if you have not already done so.

Since I have treated you for a previous condition, I have records which your new physician can use. Upon receipt of your written approval, I will make available to your new physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

For your convenience I enclose a form that you may use to give me such written approval.

Very truly yours,

_____M.D.

(Enclose Form 2)

FORM 2

AUTHORIZATION TO DISCLOSE INFORMATION TO NEW PHYSICIAN

I authorize _____, M.D., my former physician, to disclose complete information to my present physician, _____, M.D., concerning medical findings and treatment from about _____ 19____ until the date of this authorization.

Signed _____

Place _____

Date_____

Witness _____

Witness _____

He must give the patient proper notice that he is w drawing from the case and must give the patient a reas able amount of time to obtain a new physician. Wha a reasonable amount of time will depend upon the cumstances of the case and the availability of other p sicians in the area. We suggest that under most circ stances that the time set forth be not less than five days. To provide a record and protect the physicia letter should be sent to the patient. If the letter is sent certified mail with a return receipt requested, the physic will have record in his file showing not only that patient was notified, but also the date the patient recei the notification. Form 3 (example on page 26) is app priate for this purpose. We suggest that you may wish enclose Form 2 with the letter for the patient's c venience.

c. Discharge of a physician

The patient may also terminate the contract by charging the physician. The physician will want to m an immediate and adequate record that he did not ab don the patient. The physician may do well to try to tain from the patient a signed statement of the facts discharge of the physician. Where this is not available suggest that the physician send a letter to the patient s as Form 4. Again, the enclosure of Form 2 is appropri We suggest the letter be sent by certified mail, with a turn receipt requested so that your file will show rec of the letter by the patient.

3. Special problems during treatment

There are many problems that can arise during the tr ment of a patient. The ones covered in this section ar particular importance to the physician since, if no p

FORM 3

LETTER OF WITHDRAWAL FROM CASE

Dear Mr. _____:

I find it necessary to inform you that I am withdrawin from further professional attendance upon you for th reason that you have persisted in refusing to follow m medical advice and treatment.

Since your condition requires medical attention, I sug gest that you place yourself under the care of anothe physician without delay. If you so desire, I shall be avail able professionally to attend you for a reasonable tim after you have received this letter, either for regular o emergency medical treatment, but in no event for mor than _____ days following such receipt. This shoul give you ample time to select a physician of your choic from the many competent practitioners in this area.

With your written approval, I will make available t this physician your case history and complete informatio regarding the diagnosis and treatment which you hav received from me.

Very truly yours,

_____, M.D

Enclosure Form 2

ve steps are taken and a record made of such steps, defense against allegations of malpractice could be le considerably harder and more expensive.

. Patient who fails to follow advice

/here a physician feels that a certain treatment or proire should be done and the patient refuses, a record ıld be made. Form 5 may be adapted to the situation occurs.

. Patient who fails to keep appointment

a patient fails to keep an appointment where the ent has a condition the physician knows needs treat-t, the physician should make this fact known to the ent. The physician, at the same time, should see that records reflect his professional advice to the patient. tter such as Form 6 should be sent to the patient.

. Patient who leaves hospital against medical advice

ases arise where patients refuse to remain in a hospital though their physician feels that continued hospitalon is necessary. Form 7 (example on page 27) pros a statement that the patient may sign which will ase liability for the patient's acts. The physician should e two witnesses with him at the time he informs the ent of the reasons the physician feels indicate the need continued hospitalization. These witnesses should sign form whether the patient signs the form or not. If the ent refuses to sign, that fact should be noted on the n. The physician should have a copy of the form for office records. The hospital will also want a copy for ecords.

. Substitute physician in obstetrical cases

is not unusual for a physician to be unable to be ent at a delivery, even though the physician would to be there. Another delivery might be in progress or speed of delivery might make it impossible for the ician to get to the place of delivery. The physician ıld explain this to his obstetrical patient when she first es to his office. The physician should have the exant mother sign a form such as Form 8 as an acknowlnent of the fact that she understands and agrees.

. Office treatment

ome procedures can be done either in the physician's e or in the hospital. Where the physician decides to he procedure in his office he should inform the patient he alternatives and any special risks involved. If the ent decides that the procedure should be done in the ital, the physician should not attempt to do the proire in his office. If the patient does agree to having the edure in the office, then the physician should have atient sign a consent such as Form 9.

. Confidential and privileged relationship

Wisconsin, communications between a patient and hysician are protected both by law and ethics.

nder Wisconsin law, certain disclosures made by a ent to his physician in order to give the physician sufficient information to enable him to treat the patient are "privileged." This "privilege" means that the statements cannot be disclosed by the physician unless the patient allows it or unless the physician is allowed or required by law to disclose them. The "privilege" is that of the patient, and can ordinarily be claimed or released only by the patient.

Confidential communications involve a physician's ethical duty to keep secret the information he has obtained about a patient while acting in his professional capacity. This obligation is independent of the privilege discussed in the preceding paragraph. It is binding on the physician at all times.

Wisconsin Statutes permit the right of an employee or the employee's designated representative to inspect personal medical records concerning the employee contained in the employer's file. If the employer believes that disclosure of an employee's medical records would have a detrimental effect on the employee, the employer may release the medical records to the employee's physician or through a physician designated by the employee, in which case the physician may release the medical records to the employee's immediate family.

Unauthorized disclosure of confidential information can be grounds for revocation of the physician's license. It may also be the basis for a suit for damages by the patient. Each physician therefore must exercise care to protect against unauthorized disclosure of confidential or privileged information.

FORM 7

STATEMENT OF PATIENT LEAVING HOSPITAL AGAINST MEDICAL ADVICE

This is to certify that I am leaving _____ Hospital at my own insistence and against the advice of my attending physician and hospital authorities. I have been informed by them of the dangers attendant on my leaving the hospital at this time. I assume all responsibility for any results caused by leaving the hospital prematurely, and I hereby release my attending physician and the hospital, its employees and officers from all liability for any and all conditions, complications and results.

_____

I hereby agree to hold harmless my attending physician and the _____ Hospital, its employees and officers, from all liability of whatsoever nature, with reference to the discharge of the patient named above.

_____

(husband, wife, parent, etc.)

Date _____

Signed in the presence of:

Witness _____

Witness _____

NOTE: If the patient refuses to sign such a statement, he cannot be forced to do so, legally, nor may his release be withheld until he signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement made on the form "signature refused."

a. Release of patient health care records

By earlier case law and now by statute, a patient's health care records (all records related to the health of a patient prepared by or under the supervision of a health care provider) may ordinarily only be released on the authorization of the patient or one legally permitted to act for the patient. The law defines "informed consent" with respect to the disclosure of information from a patient as written consent "containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to which disclosure may be made, the type of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective." Wis. Stats. §146.81 (2). In making a release of medical records, the physician should very carefully review the authorization to assure that the release is made strictly in accordance with the authorization.

(1) Access without informed consent. Release of medical records without patient authorization, unless specifically permitted by law, is a breach of confidentiality and may subject the physician to a lawsuit. The law permits the release of patient health care records upon request without informed consent in the following circumstances:

(a) To staff, accreditation or review committees.

(b) For performance of health care services to persons providing such services (including emergency care) or being consulted in regard to such services.

(c) For billing, collection, and payment of claims.

(d) Under court order.

(e) On written request from an appropriate government agency.

(f) For research purposes under specific conditions.

FORM 16

STATEMENT OF NEED FOR THERAPEUTIC ABORTION

We find from observation and examination of _____ _____ that she is pregnant, that she is suffering from the following ailment or condition: _____, and that it is medically necessary to perform a therapeutic abortion upon her. Further progress of her pregnancy would gravely endanger or imperil her life. We therefore recommend that a therapeutic abortion be performed.

Date _____

(1) _____

(2) _____

(3) _____

(duly licensed physicians)

NOTE: An abortion is not a crime when performed for therapeutic purposes, that is, when it is necessary to save the life of the patient. The physician should be in a position to establish the therapeutic ground upon which he justified action. In order to best protect himself in this regard, he should obtain and preserve in his file a statement such as the above, signed by at least three reputable physicians (including himself) that they have examined the patient and are of the opinion that an abortion is a medical necessity.

(2) Patient access to health care records. Any pati or other person may, upon submitting a statement of formed consent, (a) inspect the patient's records dur regular business hours upon reasonable notice, (b) rece a copy of the patient's records on payment of reasona costs, (c) receive a copy of the patient's x-ray reports have the patient's x-ray films referred to a provider of choice for analysis upon payment of reasonable co Wis. Stats. §146.83.

b. Photographs

Physicians may wish to make a visual record o case for several reasons. In cosmetic surgery it may sh the result of the surgery. In other cases it may show result of a particular method of treatment. It may also used for unusual cases where documentation would valuable for teaching purposes. In any of these cases th must be a release of the confidential or privileged relati ship to allow the taking of photographs.

c. Observers, motion pictures, television

In cases similar to those where photographs may desirable, there are cases which should be observed, t vised or recorded on film. The release of the confiden or privileged relationship must also be obtained in th cases. Forms 13, 14 and 15 may be used for these uations.

VI. Special situations

There are certain procedures which the physician sho approach with caution and be sure to take the necess steps to document what has happened and, to be s that he proceeds only with proper authority.

1. ABORTIONS

Under Wisconsin Statutes there are limited situatic in which an abortion may be legally performed. One these is the therapeutic abortion and Form 16 (exam on page 28) provides the record necessary to meet requirements of Wisconsin Statutes for such a procedu Form 17 is a model for a statement by a patient to be u in connection with the treatment of a recent or par abortion.

The law as it regards abortion is currently unsett While Wisconsin Statutes strictly limit the conditic under which an abortion may be performed, this statu at least as to certain factual applications, has been ru unconstitutional. It is recommended that prior to condu ing any abortions each physician consult his personal torney as to the legality of his proposed course of action.

2. ARTIFICIAL INSEMINATION

There are two types of artificial insemination. F where the husband's semen is used and, second, where semen of a male other than the husband is used.

a. Artificial insemination—homologous

AIH involves the use of the husband's semen to tempt to make the wife pregnant. A consent should signed by both the husband and the wife. Form 18 c

b used for this purpose. It is believed there is no legal cnplication for this situation.

b. Artificial insemination—donor

AID involves the use of the semen of a male other n the husband. In such cases there are persons other n the husband and wife to consider, namely, the donor, l if he be married, his wife.

The husband and wife must consent. Form 19 provides this.

n this situation we also recommend that the donor l his wife execute consents such as Forms 20 and 21.

There is a diversity of opinion on the legality and mor- y of this type of artificial insemination. It is recom- nnded that prior to the use of these forms each physician isult his personal attorney.

3 STERILIZATION

n Wisconsin, neither therapeutic nor non-therapeutic ilization is a crime according to a 1968 opinion of the Ste Attorney General. Sterilization can result from three arate situations.

a. Sterilization as a result of an operation for other purposes

Some cases can result in sterilization, although the pose of the operation is not to achieve sterilization. Ts risk must be explained to the patient in terms that he can understand. Then the physician should have the patient sign a separate consent form for this express purpose. Form 22 can be used for this purpose. The spouse should be urged to sign the consent. This is to avoid later statements by the spouse that he or she knew nothing about the possibility of sterilization.

b. Therapeutic sterilization

Medical reasons exist for operations which are intended to sterilize the patient. In such cases a consent should be obtained from both the husband and the wife. Form 23 can be used for this procedure.

c. Non-therapeutic sterilization

Requests for non-therapeutic sterilization should be the subject of a conference with both the husband and the wife. The nature of the operation, the fact that it cannot be guaranteed as 100% effective, should all be explained in detail. Then, if they wish to proceed, a consent such as Form 24 should be signed.

VII. Other consent forms

There are other forms included in the January 1970 "Blue Book" printing that may be of common use to a physician. These forms are believed not to require explanatory text. However, before any of these forms are signed, the physician should review the requirements for a valid consent given earlier in this article. ■

MINOR'S CONSENT

A common question from physicians throughout the state is under what circumstances may a physician provide medical services to a minor without parental consent.

As a general rule, consent for medical services to be provided to an unemancipated minor must be given by the minor's parent or guardian. Under appropriate circumstances a court may give consent in lieu of a parent.

Emancipation occurs when a minor is no longer under parental care and custody. A common example of emancipation is marriage by a minor.

Wisconsin law also provides that a minor may receive diagnosis of and treatment for venereal disease without parental consent. Attempts to expand this law to cover other specific fields of medical care (abortion, contraception, and drug abuse) have been unsuccessful.

This area of the law, parental rights versus minors' right of privacy, is now quite active and physicians should be alert to rulings which bear on this conflict.

ABORTION

Wisconsin, like several other states, has a law denying subsidies from any public source for non-therapeutic abortions except in cases in which conception results from sexual assault or incest. Laws of this nature have been subject to challenge in the courts in other states. The validity of Wisconsin's law, if challenged, cannot be predicted.

In Wisconsin spousal consent for abortions is not required by law. Medical Assistance (Title XIX) does fund abortions.

Physicians and hospitals are granted immunity from civil liability for refusal to perform abortions. In the case of the physician this immunity is conditioned on the refusal having been based on religious or moral precepts.

Guidelines for Implementation of Joint Practice of Physicians and Nurses

Prepared by Joint Practice Committee of the State Medical Society of Wisconsin and Wisconsin Nurses Association
Approved by the Council of the State Medical Society of Wisconsin, March 5, 1977.

What is joint practice?

Nurses and physicians practicing together within the framework of their respective practice acts and other guidelines (such as joint practice statements issued by their professional organizations) who modify and develop their practice relationships and patterns to make each other's competence and contribution to health care more effective. The services provided to clients are complementary but not interchangeable either in responsibility or accountability. The collaboration includes both independent and cooperative decision-making and is based on the preparation and ability of each practitioner. The nurse may be in a satellite location, consulting with the physician in accord with mutually developed care protocols. A complete definition of joint practice would involve all health professions, the entire health delivery system, and even the concept of health.

The mere fact of working together does not necessarily constitute joint practice since the physician and nurse may not be practicing in a collaborative, collegial way.

What is a joint practice statement?

A joint practice statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The Joint Practice Committee of the State Medical Society of Wisconsin and the Wisconsin Nurses Association developed a Joint Practice Statement in 1974 to assist physicians and nurses. The Statement accompanies these guidelines (see adjacent box). The Statement was approved by the House of Delegates of the State Medical Society and Wisconsin Nurses Association and formally endorsed by the State of Wisconsin Board of Nursing. The Medical Examining Board has officially recognized the need for the development of joint practice arrangements in accord with the principles enumerated in the Statement.

In addition to joint practice committees at the state level, the National Joint Practice Commission, composed of eight members each from the American Medical Association and the American Nurses Association, facilitates joint practice efforts nationally.

How are local joint practice committees established?

In each health care delivery setting involving the pr tice of registered nurses and physicians, it is adva tageous to have them affiliate in joint practice committ to provide both with an organizational base, a colleg advisory group, and a channel of communication.[1]

If one physician and nurse are practicing togeth they can constitute the joint practice committee. In lar settings membership should include nurse and physici representation and can extend to other health prof sionals and administrative personnel.

These local joint practice committees should establ written policies and standards of performance and revi them periodically.[1] The committee also serves as an visory and interpretive body to the various staffs in t setting.

Involvement in district, regional, and state joint pr tice efforts also is encouraged and helpful.

Are special credentials required for joint practice?

It is imperative that nurses in joint practice be ed cationally prepared and professionally competent for th extended function. They must be clinically competent a able to assume responsibility for their decisions and ac Written evidence of the nurses educational preparatic experience, continuing education, and periodic evaluati should be on file and available for external review.

Educational programs for the preparation of register nurse practitioners in extended roles should be develop by nursing in consultation with medicine and should carried out, wherever possible, under the aegis of credited educational institutions.[1]

Physicians need to examine their qualifications a readiness for joint practice, and not all nurses are p fessionally or personally prepared for such practice. adequacies in either professional are not conducive success in joint practice.

How do the nurse and physician relate to each other in joint practice?

Interdependent relationships and willingness to formulate roles are facilitated when practitioners are m ture, experienced, and comfortable in their own ro Persons who need to define and defend professional t ritory and who operate with defensive attitudes are n good candidates for joint practice. The goal of jo practice is to improve health care, not to protect or p

ve professional prerogatives. The success of joint ctice is dependent on the attitudes, sincerity, and com- ment of the persons involved.

Time and experience together are required to develop owledge of each other, trust, and confidence. Mutual fidence is the crux of the relationship and will be com- nicated to others.

Certain mechanisms can assist the development of the tionship such as using problem-oriented records, iodically reviewing cases together, developing care ns jointly, and formally evaluating the pattern of re- ng to each other and caring for patients.

w do patients accept joint practice?

The focus of joint practice is on the needs of the patient l how the practice arrangement can meet them. Patient choice and preference continue to be preserved. The evident concern for the patient is conducive to acceptance.

The mutual respect and confidence in each other displayed by the physician and nurse are key determinants in patient acceptance.

Joint practice has evolved to improve the quality, availability, and accessibility of health care. If these ends are being achieved, greater patient satisfaction should be a consequence.

How is the quality of patient care maintained and improved?

Nurses and physicians, through collaboration, have the greatest potential to improve the quality, and increase the quantity, of health care.

State Medical Society of Wisconsin and Wisconsin Nurses Association

Statement on Joint Practice

Approved by the Council of the State Medical Society of Wisconsin, May 18, 1974, and endorsed by the October 9-11, 1974 WNA House of Delegates and the State of Wisconsin Board of Nursing. The Medical Examining Board recognizes the need for the development of joint practice arrangements in accord with the principles enumerated in the Statement.

This Statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The State Medical Society of Wisconsin and Wisconsin Nurses Association cannot through this Statement alter the legal authority of the physician or registered nurse. However, the application of the following principles of joint practice can substantially improve the quality, availability and accessibility of health care for the people of Wisconsin.

• The health and best interest of the recipients of care are foremost considerations in all practice arrangements.

• The degree of professional responsibility vested in the physician or registered nurse is related to education, experience, competence, and licensure. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform.

• Medical and nursing services are complementary but they are not interchangeable either in responsibility or accountability. Each practitioner is accountable and responsible for the quality of care rendered. Each practitioner is responsible for the maintenance and improvement of practice proficiency.

• Each practitioner should receive remuneration commensurate with qualifications and proficiency.

• Medical and nursing collaboration includes both independent and cooperative decision-making. Mutually developed protocols can clarify shared responsibilities and delegated functions.

• Educational programs for the preparation of registered nurse practitioners in extended roles should be developed by nursing in consultation with medicine and should be carried out, wherever possible, under the aegis of accredited educational institutions.

• It is advantageous to have physicians and registered nurses affiliate in joint practice committees in order to provide both with an organizational base, a collegial advisory group, and a channel of communication.

• In each health care delivery setting involving the practice of registered nurses and physicians, a joint practice committee should establish written policies and standards of performance. Such policies and standards should be reviewed periodically.

• It is important to maintain a flexible and innovative approach in the evolving role realignment of registered nurses and physicians. Differences in recipient populations, in how they are served, and in the composition of practitioners working in a setting, will influence what each practitioner regularly does.

1. In developing this Statement the joint position statements on practice of the following medical and nurses associations were consulted and utilized: California, Canada, Florida and Idaho.

The health and best interest of the patient remains the foremost consideration in all practice arrangements.[1]

Each practitioner is accountable to the patient and to each other for the quality of care rendered individually and collectively.

The local joint practice committee should establish written policies and standards of performance and systematically review those standards and resultant care periodically. Evidence of the review should be maintained. The committee should make recommendations for improvement of care and monitor their implementation.

Are protocols necessary?

Medical and nursing collaboration includes both independent and cooperative decision-making. Mutually developed protocols can clarify shared responsibilities and delegated functions.[1] Protocols are helpful for practical purposes, for insuring quality, and for legal reference if required.

Published protocols are increasingly available for reference in professional journals and books. Consultation also can be obtained for the development and review of protocols. Protocols should be reviewed and updated regularly.

A general protocol should be available which describes how the nurse and physician in that setting practice with each other.

How does joint practice affect professional liability?

The physician has definitive legal responsibility and ultimate accountability in matters of medical care. However, the nurse shares in this accountability and remains legally responsible for decisions and actions in the practice of nursing. Each practitioner should be properly identified to the patient.

All professionals are expected to exercise judgment about the limits of their individual competence. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform. Each practitioner is responsible for maintenance and improvement of practice proficiency.[1]

There is no evidence of an increase in malpractice suits stemming from joint practice. Joint practice can lessen malpractice concerns because of improved, complementary care and shared accountability.

The Joint Practice Statement is admissible as evidence in court. If the practitioners are observing the guidelines in the Statement, they are practicing the "best care available" at the time.

What is the legal base for joint practice?

Practice acts (licensing laws) were enacted in the public interest to safeguard care and are not primarily for the protection of the practitioner.

The present medical and nurse practice acts in Wisconsin permit joint practice. The nurse functions under the nurse practice act and not under the physician assista portion of the medical practice act.

Practice acts are phrased in broad terms to acco modate changes and advances without the necessity f statutory revision. The National Joint Practice Comm sion recommends that "practice acts which are bro enough to permit flexibility within the confines of lic sure be left as they are and that statements addressi themselves to the issues of role realignment and adju ment be initiated by State Joint Practice Committees other joint bodies of medicine and nursing."[2]

A joint practice statement embodies guiding princip and professional opinion on elements of joint practice physicians and registered nurses in any setting. The au ority of the Statement testifies to mutually agreed up principles of practice. The Statement can be used to va date generally acceptable practices or patterns of care a to respond effectively and responsibly to new needs a methods of providing care.[1]

The degree of professional responsibility vested in t physician or registered nurse is related to education, e perience, competence, and licensure.[1]

How does joint practice affect the organization for care?

Both nurses and physicians should participate in co mittees which focus on patient care and the practice e vironment and organization. They also should be direc involved or represented in the administrative structu Their active participation in community activities relat to health care will enable interpretation of joint practi along with their broader contribution.

The nurse needs space, privacy, furniture, and equi ment to enable assessment of, and conferencing with, p tients. Other facilitating arrangements may include ternate examining rooms and a health education room.

Components in the practice should be evaluated f enlargement, enhancement, or initiation such as patie education; periodic examinations; visits to homes, nursi homes, or other residential settings; conferences with oth care providers in the community, family oriented practi and satellite possibilities.

Various scheduling patterns evolve in accord w individual and practice factors. The nurse may perfo the initial assessment and triage of patients, provide c going supervision of patients within mutually develop protocols, and develop a specific caseload. Some pr titioners prefer alternation of visits between the physici and nurse with consultation as needed. The nurse m share on-call responsibilities.

Patient choice is preserved.

Maintaining continuity and rapport are important.

Joint practice should provide something more, not les

What about patient charges?

Patient charges are determined by the providers i volved. In some settings there is a uniform charge r matter who provides the service. The fee schedule for joint practice should be arrived at jointly.

Third party payment also enters into the consideration c patient charges. Some third party payers directly reim- trse the services of nurse practitioners.

Health education costs must be included in reimburse- rnt plans.

ow is the nurse compensated?

Each practitioner should receive remuneration com- nsurate with qualifications and proficiency.[1]

Some nurses receive a salary; others are part of the cporate structure. The contribution of the nurse should t reflected in the productivity of the practice. The com- nsation of the nurse should be individually negotiated d reflect the responsibility assumed.

hat about staff privileges hospitals and other institutions?

Institutional acceptance and implementation of joint actice is important and worth the effort.

The statutes and joint practice statements authorize jnt practice, but specific delineation of privileges is left t the hospital or other facility. Privileges should be col- oratively determined and granted by nursing and dical staff. It is the spirit of these privileges that the rse will work with, not in place of, the physician.

hat other measures are helpful interpreting joint practice?

Explanation of the purpose and methods of joint pctice to patients, their families, other physicians and rses, office and administrative personnel, other care pviders, pharmacists, and the general public can be pful.

Demonstrated skill is more convincing than expla- ion.

y other suggestions?

Historically, there has been a continual realignment o the functions of the nurse and physician. The rising nand for health services and the increased competence c nurses are hastening this transition. However, external ents and statutes facilitate joint practice; they do not pose or guarantee it. Joint practice can be achieved only t the practitioners involved.

Role innovation may be easier where physicians are sce, but the joint practice model has validity and ad- vtages in most, if not all, settings.

A last suggestion would be to emphasize the importance o remaining open and flexible in order to respond to nds, to make adaptation, and to realize more fully the elving contributions of the practitioners involved.

REFERENCES

1 tate Medical Society of Wisconsin and Wisconsin Nurses Association tatement on Joint Practice, 1974 (see adjacent box).

2 National Joint Practice Commission. *NJPC Statement on Medical and Nurse Practice Acts*, Chicago: The Commission, 1974. ■

THE WISCONSIN POISON CONTROL PROGRAM NETWORK

It is a health service that provides standardized poison management information and treatment to both medical professionals and the general public through a network of regional and satellite centers.

Each center is staffed by specially trained poison information professionals available to answer telephone inquiries 24 hours a day, seven days a week. Telecopying equipment enables the staff to make immediate contact with national headquarters in Pittsburgh when additional information or research is needed on difficult cases of ingestion.

The centers:

- recommend treatment procedures to physicians and to the public in poison emergencies.
- maintain a record of calls received, treatment advised or given and disposition of the case.
- report certain poison incidents to the Division of Health.

The two regional centers are:

Milwaukee Poison Center
Milwaukee Children's Hospital
1700 W Wisconsin Avenue
Milwaukee, WI 53233
Tel 414/931-4114

Poison Center — Madison Area
University Hospitals
600 Highland Avenue
Madison, WI 53792
Tel 608/262-3702

The three satellite centers are:

Eau Claire Poison Center
Luther Hospital
310 Chestnut Street
Eau Claire, WI 54701
Tel 715/835-1515

Green Bay Poison Center
St Vincent Hospital
P O Box 1221
Green Bay, WI 54305
Tel 414/432-8621

LaCrosse Poison Center
St Francis Hospital
709 South 10th Street
LaCrosse, WI 54601
Tel 608/784-3971

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the

WISCONSIN DEPARTMENT OF HEALTH
AND SOCIAL SERVICES
DIVISION OF HEALTH

PO Box 309 Madison, Wis 53701

Physician and Hospital Records: Retention and Inspection

A. Retention of Records

It is generally agreed that ownership of medical and hospital records rests, respectively, with the physician and the hospital. Their beneficial ownership, that is the right to have them used for one's benefit, is in the patient although the right to possession remains in the physician or hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because of the long-standing uncertainty regarding the rights of physicians, hospital personnel, patients and others in regard to health care records, efforts both statutory and private have been made to clarify this situation. In 1959 the State Medical Society of Wisconsin and the Wisconsin Hospital Association jointly developed an *Interpretation* seeking to define what is a health record and restate the respective rights of various interested parties in them. This *Interpretation* was printed in the June 1975 Blue Book issue of the *Wisconsin Medical Journal.* (74 *WMJ* 30)

The law under which the *Interpretation* was prepared has been subsequently amended. To the extent of that amendment, the *Interpretation* is no longer valid. It does provide a framework from which to view the issues involved, this framework having been developed jointly by the health professionals most directly involved. The new statute, Sec. 804.10(4), Wis. Stats., is discussed in the box accompanying this article. It deals with authorization by a patient for the examination or inspection of that patient's health care records.

More recently, Secs. 146.81-.83, Wis. Stats., were enacted effective 1980. This new law deals with the release of health care records by consent and without consent. Health care records are defined as "all records related to the health of a patient prepared by or under the supervision of a health care provider." Consent may be given by the patient or one legally permitted to act on the patient's behalf. Consent must contain the name of the patient, the purpose of disclosure of the records, the type of information to be disclosed, the person to whom disclosure may be made, which providers are to make the disclosure, and the time period during which the consent is effective. Access without consent of the patient is permitted for staff, accreditation or review committee use, performance of health care services or consultation regarding them, billing, collecting and payment of claims, on court order, on written request from an appropriate government agency, and for research purposes subject to particular conditions. The new law also covers the subject of patient access to health care records.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 18 who are mentally competent; (2) over 18 who are mentally ill; and (3) under 18.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not legal considerations.
2. A mentally normal patient of legal age has *3* years within which to sue *for personal injuries.* If a patient elects to sue on *a contract* rather than for alleged *negligence,* he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. There is no *legal* requirement for accommodating a former patient longer than the suggested 6 years, although where fraud is alleged, the injured party has 6 years in which to sue *after* discovery of the fraud. For example, a surgeon is chargeable with "fraud" who is aware he has left a foreign object in a patient's body but does not disclose that fact to the patient, or the latter's representative.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be sum-

marized as follows:

A. If the patient is over 18 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.

B. If the patient is over 18 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within one year of his recovery, and if he does not recover, within a maximum of 8 years after the alleged negligence.

C. If the patient is a mentally normal minor at the time of treatment or hospitalization, suit for injuries resulting from alleged malpractice by a health care provider must be brought on behalf of the minor within the later of: (i) 3 years after the injury or (ii) one year from the date the injury was, or should have been, discovered within a maximum of five years after the alleged injury, or (iii) the time the minor reaches the age of 10.

D. If the patient was a minor and mentally ill at the time of the alleged negligence, and becomes mentally normal by age 18, he must sue for the alleged negligence by the time he is 20, or within three years from the date of the injury, whichever is later. If such patient remains insane after reaching age 18, his guardian must start suit within two years of his recovery, or before the patient is 20, whichever occurs later, all within a maximum of eight years after the alleged negligence.

4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record ı microfilm or similar process is as fully admissible ·fore a court as the original itself. *Therefore, the originals your records, once they are microfilmed, may be de-'oyed. However, it is advisable to keep the original record r at least 3 years or until the patient has paid your bill.* ıe reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;

2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

Inspection and Copying of Medical Records and Reports

Both the old and revised subsections limited the right inspect and copy medical or hospital records and reports situations where *no litigation* is pending respecting the edical care and treatment covered by the authorization. nce litigation is begun, situations involving the inspection copying of medical records and reports are governed by her statutes. The revised text of the subsection, renumbered as 804.10 (4), which took effect January 1, 1976, is set out in the box on page 27 of this article.

A physician or hospital administrator, and anyone designated by either of them is urged to read this article *before* allowing the inspection or copying of medical records and reports which are in his custody.

An authorization from or on behalf of a patient allowing the designated person to inspect and copy medical or hospital records or reports concerning the patient's care

STATUTE

Former Section 269.57 (4) of the Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization was revised and renumbered as of January 1, 1976, to read:

> "804.10 (4). Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

NOTES: The principal differences between the old and new statutes are:

1. The earlier statute permitted the inspection and copy on the written authorization of a patient or his representative of "any medical or hospital reports, photographs, records, papers and writings concerning [his] care or treatment."

The revised subsection imposes narrower requirements limited to "medical or hospital records or reports."

2. Former Section 269.57 (4) provided that a custodian of medical or hospital records who refused to comply with an authorization submitted by or on behalf of a patient was liable to such patient "for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs."

Section 804.10 (4) provides that such custodian "shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover." This is a much more severe penalty.

and treatment may not specify what specific records are covered. The physician on the other hand may have records that go back many years and cover more than one treatment or series of treatments, and more than one illness or hospitalization, or more than one member of a family.

Before complying with the request of a patient to inspect and copy his records, the physician should confer, if practical, with the patient or his representative to ascertain *what* illness, *what* treatment, and *what* period of time are intended by the authorization. If by any chance the records or reports contain material relating to conditions which would be embarrassing to the patient or which might involve other members of the immediate family, the patient or a representative might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any such parties.

Some physicians are requesting not only that the time periods to be copied from a medical record or report be specified, but also that each particular illness be specified in the authorization from the patient.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member.

Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Following are some major considerations and safeguards to be observed by a custodian of medical records and reports:

1. Validity of Authorization

Upon being presented with an authorization form for the inspection or copying of medical records and reports, physicians or hospitals must assure themselves that (1) the patient in fact signed the authorization, (2) was of legal age, and (3) had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian. Where there is no formal guardianship of a minor, a parent may sign as the natural guardian except where the minor is emancipated as by marriage or self-support.

The physician or hospital must take such precautions as are necessary to satisfy themselves that those designated in the authorization are thereby empowered to inspect and copy the medical records or reports covered by the authorization.

The physician or hospital representatives must also be satisfied that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the physician (or his representa tive) or the hospital (or his representative), depending up on which place the authorization is presented, is warrante in refusing to honor such authorization. The same is tru if there is any substantial question as to the authenticity o the signature or the mental capacity or age of the patient

The statute authorizes the personal representative, o the beneficiary of a life insurance policy, to sign a authorization in case of a patient's death. If you receiv such an authorization you can ask the personal repre sentative to provide you with a certified copy of his au thority to act. This will take the form of "Domiciliar Letters" or other documentary evidence of appointmen or authorization which are issued by the Circuit Cour branch handling probate matters.

In the case of the beneficiary of life insurance, yo can ask for a certified statement from the insurance com pany that (1) a policy on the patient was in force at th time of his death, and (2) the person signing the authori zation is the beneficiary under the policy.

The burden of proof is on the person seeking the in formation and the physician has no duty to release such in formation until he is satisfied that the person asking i so authorized. On being satisfied that the authorizatio presented is properly signed, as previously outlined, tha the person presenting it is the person named therein, an that no question of mental capacity or of minority i involved, it then becomes the duty of the physician o hospital to permit such person to inspect and copy "an medical or hospital records or reports concerning" th care or treatment designated in the authorization. Exactl *what* records and reports may be inspected and copie is discussed in point 2 immediately following.

2. What Can Be Inspected And Copied

It is first necessary to determine what must be mad available for inspection and/or copying.

It is believed that under a fair interpretation of sub section (4) the physician's records and reports (office o hospital), and the hospital clinical record or chart shoul be made available for inspection or copying.

In the case of x-rays there seems to be some dis agreement among legal authorities as to whether the are part of the medical record as such, or are technicall photographs. It is advised that x-rays be inspected *onl* under proper supervision, in the case of a physician's of fice by the physician in charge, an associate, or the de signee of either, in the case of a hospital or other institu tion by a qualified physician, or in the event of his un availability, by a person designated by the administrato

X-rays must *not* be taken from the office of a phy sician or other custodian unless required by a court orde or subpoena. When either of the latter is served on th custodian of medical records or reports, Section 804.10 (4 *is no longer applicable*, and the authorization is no longe in force.

One of the results of the increasingly comprehensiv services of the modern hospital, especially teaching insti tutions, is the development and maintenance of *two* type of records relating to a patient. One relates directly to hi care and treatment, and is the direct professional responsi bility of the attending physician and of those acting unde him, and may be described as the "official records an

reports". The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record or report, other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, technically relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute. Nothing but one of the above should be furnished for inspection or copy.

Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, are not licensed to practice medicine, and are not necessarily recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic "records" relating to the care or treatment of the patient.

3. Safeguards

The following safeguards are recommended:

(a) Section 804.10(4) does *not* in words or by implication, give a right *to remove* any records from a physician's office, or hospital, the records being the legal property of the physician or hospital.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on *in the presence* of a custodian (hospital or physician), or the representative of either. The statute does *not* require a physician or hospital, to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted. The physician or hospital making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital records or reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

(b) Few people, other than medically trained personnel, know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

(c) The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but as soon as the convenience of a physician, an administrator, or a record librarian, *reasonably* permits, after taking into account the urgency of prior demands on their time and personnel and whether advance notice had been given of the demand of the particular patient.

(d) When there is any indication that legal proceedings may ensue, the physician or hospital served with a proper authorization to examine or copy a patient's records should promptly notify the insurance carrier of this fact, and also the attorney of the physician or hospital. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such authorization be given by the person receiving same to the other interested parties.

4. No Authorization Forms Suggested

Since no words appear in Section 804.10(4) prescribing the form of an authorization to inspect and copy a patient's medical or hospital records or reports concerning his care or treatment, model forms are not suggested. The observance of the precautions and safeguards emphasized earlier in this article should assure that the patient's interest is protected while at the same time protecting the professional or institutional provider of services.

As a final observation, although legal title to medical records and reports is in the physician or hospital, depending on their location, the general legal opinion is that such records and reports are held in the custody of the physician or hospital for the benefit of the patient. It is on that basis that they are made limitedly available to him or to persons designated by him. ■

AUTOPSY

Question: Whose consent is required to permit a physician to conduct an autopsy?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin. If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Section 979.125, Wisconsin Statutes, adopted in 1978, requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object.

"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

Adoption

STATE LAW REGULATES the adoption of children and licenses the agencies involved in adoptive placements to the problems and abuses inherent in "black market" adoptions.

Licensed private child welfare agencies and special governmental agencies are authorized to take custody of children, become their guardians, provide care and maintenance for them, place them in foster homes (which must also be licensed) and initiate necessary steps leading to adoption.

No one else may perform these functions in the adoptive process and the physician must be careful to refer patients either having a child for adoption or seeking to adopt to the appropriate agencies. (See box on this page.)

Placement of a child for adoption or receipt of such a placement may subject those involved, including an intermediary, to criminal prosecution. Failure of the parties to follow legally established procedures for adoption is grounds for a court to refuse to grant the adoption.

Similar precautions are taken with interstate adoption situations and consent must be obtained from the Department of Health and Social Services before any child is brought into Wisconsin or sent from this state for adoption. ■

GOOD SAMARITAN LAW

The Legislature has broadened the immunity provided by the Wisconsin Good Samaritan Law to cover any person rendering aid at the scene of an emergency. First enacted to protect physicians, these laws are common throughout the United States. They are designed to encourage prompt care for persons who are injured or become ill away from normal locations where treatment is given.

The scene of an emergency does not include a hospital or physician's office. Persons employed and trained to render emergency care, acting for compensation and within the scope of their employment are not protected under the law.

WISCONSIN ADOPTION AGENCIES

Licensed Voluntary Agencies

Catholic Social Services—Diocese of Green Bay, 131 South Madison St, PO Box 38, Green Bay 54305

Catholic Charities, Inc,—Diocese of LaCrosse, 128 South 6th St, PO Box 266, LaCrosse 54601

Catholic Social Services—Diocese of Madison, 25 South Hancock St, Madison 53703

Catholic Social Services of the Archdiocese of Milwaukee, Inc, 207 East Michigan St, Milwaukee 53202

Children's Service Society of Wisconsin, 610 North Jackson St, Milwaukee 53202

Lutheran Children's Friend Society, 8138 Harwood Ave, PO Box 13367, Wauwatosa 53213

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Blvd, Milwaukee 54308

Seven Sorrows of Our Sorrowful Mother Infants' Home, Rt #1, Box 905, Necedah 54646

Wisconsin Lutheran Child and Family Service, 6800 North 76th St, Milwaukee 53233

Public Agencies

Division of Community Services (Regional Offices) (See page 101 for list of Regional Offices.)

Milwaukee County Department of Social Services, Child Welfare Division, 1220 West Vliet St, Milwaukee 53205

Maternity Homes

Lutheran Maternity Home, 1910 South Avenue, LaCrosse 54601

Rosalie Manor, 19305 West North Ave, Brookfield 53005

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Agencies licensed to make adoptive home studies and to contract with other agencies to make placements but not licensed to accept guardianship.

The Human Element, Inc, 2701 North 56th St, Milwaukee 53210

Soul, Ltd, 6185 Rosewood Dr, Appleton 54911

CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service, or moving to Wisconsin from another state, *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to disciplinary action as well as criminal penalties.

Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

THE ABUSED CHILD LAW

Abuse of children by parents and others can be found at all economic, educational, and social levels. The cumulative effect of repeated beatings or other forms of severe abuse, which may include physical crippling, brain damage or even death, must be prevented.

The Abused Child Law makes reporting of suspected cases of child abuse mandatory by physicians and others dealing with children. They are required to report cases of suspected child abuse. The law further provides that the reports be made to the city police departments, sheriffs, and county child welfare agencies. Civil as well as criminal immunity from suit is granted where a report is made in good faith. Child abuse has been made a Class E felony (punishable by a fine up to $10,000 and imprisonment up to two years).

The actions of the Legislature have immeasurably increased the probabilities that perpetrators of abuse will be identified and will receive rehabilitative help while the abused child will be extended protection from further abuse.

Relevant portions of the law, quoted from the Wisconsin Statutes, appeared in the June 1979 BLUE BOOK issue.

UNIFORM ANATOMICAL GIFT ACT

The Uniform Anatomical Gift Act, adopted by Wisconsin and some 40 other states, is a law which allows a donor to leave all or any part of his body for research or transplantation. With the continuing publicity given to transplant technology, patients may inquire about making anatomical gifts. Information or answers to questions about the donation of whole bodies for medical education and research can be obtained from the Anatomy Department, 349 Bardeen Medical Laboratories, University of Wisconsin-Madison, 1215 Linden Drive, Madison, Wis 53706 (phone 608/262-2888) or from the Department of Anatomy, The Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wis 53226 (phone 414/257-8261).

Uniform Organ Donor Cards and Decals are available from the Kidney Foundation of Wisconsin, Inc, PO Box 350, Madison, Wis 53701 (phone 608/241-1279), or 7332 West State St, Wauwatosa, Wis 53213 (phone 414/453-2830).

Regarding the donating of eyes, inquiries may be directed to the Milwaukee Eye Bank, 8700 West Wisconsin Ave, Milwaukee, Wis 53226 (phone 414/257-5543), or to The Eye Bank, E5/410 Clinical Science Center, University of Wisconsin-Madison, Center for Health Sciences, 600 Highland Ave, Madison, Wis 53792 (phone 608/263-6223).

MILWAUKEE'S PREFERRED ELEGANCE

In addition to being a city of warmth and charm, Milwaukee is one of the few cities in the world to have the distinction of hosting two members of the prestigious Preferred Hotel Association, The Pfister Hotel & Tower and The Marc Plaza. These fine Marcus hotels offer you the highest standards of elegance and hospitality known to the world. We cordially invite your inquiry for our services.

Award-winning restaurants.

Luxurious guest rooms, suites and meeting facilities.

Inviting cocktail lounges with top entertainment.

Personal and uncommon service.

The Pfister Hotel & Tower
(414) 273-8222

The Marc Plaza Hotel
(414) 271-7250

For more information write:
Ms. Rosemary Steinfest
Marcus Hotel Corporation,
424 East Wisconsin Ave.
Milwaukee, Wisconsin 53202

Name _____

Address _____

_____

Some considerations in the closing of a physician's practice

WHILE THERE ARE NO formally slated rules for closing a medical practice, there are several important items which should be considered and planned in advance. The list given below is not complete but the State Medical Society of Wisconsin believes it will be helpful.

1. Notification of patients

Patients should be given adequate notice, a minimum of three months is suggested, in writing that you plan to close your office and on what date so that they will have sufficient time to obtain another physician. It is also suggested that, in the letter of notice to the patients, you enclose a form for the patient to sign authorizing the release of records should they wish to request that a copy of their records be sent to the new physician of their choice. A list of all patients notified should be retained in your files.

You can save postage, in the case of current patients, by inserting the letter with a monthly statement or billing; letters to other patients will have to be mailed separately.

You also may wish to place an announcement in one or more local newspapers.

2. Retention of medical records

(a) Medical records, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others, should not be destroyed until the statute of limitations has expired with regard to each patient. This is because the physician's record and liability insurance policies could be your chief source of defense in a future law suit.

The Statute of Limitations has been revised to allow actions involving adults to be initiated within three years of the occurrence or one year from discovery of the injury but not later than five years from the occurrence. Actions involving minors are bound by this limitation, or age 10 years, whichever is later. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

(b) The patient has a general right to know what is in his medical records and thus you should make it known where such records can be obtained. Such records generally should not be given to the patient, but should be forwarded to another physician of the patient's choice with the consent and at the request of the patient, in writing.

(c) The Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization read:

> **"804.10 (4).** Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

3. Disposal of drug stocks

The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

> "The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, Post Office Box 28083, Central Station, Washington, D.C. 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Avenue, Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

Instructions on the disposal of non-narcotic drugs in the possession of the physician may be obtained from the Wisconsin Pharmacy Examining Board, 1400 East Washington Avenue, Madison, Wisconsin 53702.

4. Sale of medical practice

(a) If you are selling your practice, you should make certain that the buyer is a physician licensed, or eligible to be licensed, in Wisconsin. This information can be obtained from the State Medical Society or the Wisconsin Department of Regulation and Licensing.

(b) Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician.

5. Keeping your license in force

You may wish to keep your license in force and egister each year in the event that you wish to do ome consultation work or are called upon to perorm some act of medical practice in an emergency. f you elect to keep your license in force, you will be equired to continue to meet the continuing medical ducation requirements. This requirement calls for 30 ours of Category I credit as defined in the Physician's ecognition Award of the American Medical Associaion, to be accumulated every two years. The Medical xamining Board requires this regardless of extent or ature of practice; there are no exceptions due to age r retirement.

. Malpractice insurance

Your policy should be examined to determine hether it is written on a CLAIMS INCURRED or a LAIMS MADE basis. Consult your insurance agent. f the policy is written on a CLAIMS MADE basis, nly those claims made while the policy is in force ill be covered and you should either continue your overage or purchase coverage extension to protect ou until all statutes of limitation have run.

. Accounts receivable

Not all of your patients will have paid their bills y the time your practice is closed. It will be necesary to have someone available to accept, record, and eposit payments received after the official closing of our practice. You may wish, after a suitable waiting eriod of three or four months, to turn those accounts ill unpaid over to a reputable collection agency.

. Continuation of SMS membership

We hope that you will continue to be active in the ociety. This can be done by notifying your County ociety, in writing, that you are closing your practice ut wish to remain active in Society affairs. The ounty Society will notify you of its dues, if any, for active physicians. There are no dues for continuaon of SMS or AMA membership in such cases.

9. Income taxes

Copies of your income tax returns and all supporting documentation, including ledgers and accounting records, should be preserved until the Internal Revenue Service can no longer assess additional tax. For returns filed on time and containing all correct and pertinent data, this is usually three years; for returns where gross income has been understated by 20 percent or more, it is six years; for fraudulent returns or where no return has been filed there is no time limit.

10. Payroll taxes

Final returns and payments of all Federal and state withholding and Social Security taxes must be made after the last employee has been terminated and the last payroll paid.

Finally, it is recommended that you work closely with your attorney or business manager particularly on the tax aspects of closing your practice. ■

MEDIC ALERT
FOUNDATION INTERNATIONAL

The Medic Alert emblem is designed to alert emergency personnel to hidden medical conditions. On the back of the emblem is the member's hidden medical condition along with an ID number and 24-hour emergency telephone number which can be utilized to retrieve the computerized emergency medical data within seconds.

Information that is stored can include physician's telephone number, type of insurance policy, next-of-kin, blood type, medication name and dosage.

The Medic Alert Foundation estimated that one out of five Americans has a hidden medical condition, ranging from serious medication allergies to heart problems and diabetes.

In a recent twelve-month period, the service which is subscribed to by over 1.3 million people was directly credited with saving over 2,000 lives.

Free information can be obtained from Medic Alert, Turlock, California 95380. ■

Problems of a Physician's Widow/er

Following the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow/er in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow/er. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow/er will be faced with many decisions involving the settlement of the business affairs relating to the late husband's or wife's practice. It is of extreme importance that she/he act upon the advice of an attorney. When practical it is recommended that the physician acquaint his/her spouse with his/her legal and other advisors and some of his/her business affairs. This will provide an established working business relationship between the spouse and the advisors for that eventuality when she/he is called upon to act. Some of the chief problem areas the widow/er will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow/er also will be presented with the problem of what to do with the physician's narcotics. The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

> "The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch. PO Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration. 219 South Dearborn, Suite 1800, Chicago. Illinois 60604. after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration. 517 East Wisconsin Ave. Room 228A. Milwaukee, Wisconsin 53202; (414) 224-3395.

It is important that a widow/er, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his/her death may be obtained from the Wisconsin Pharmacy Examining Board, 1400 E Washington Ave, Madison, Wis 53702.

Records relating to patients, including case histories treatment records, x-rays, laboratory reports, correspondence with physicians and others should not be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow/er's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow/er can expect that the deceased physician's patient will seek care elsewhere unless he/she had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his/her patient. In such event, it is wise to insist upon a written request from the patient and his/her new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow/er should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow/er's legal and other advisors can best inform her/him how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. The widow/er should carefully follow her/his attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for the widow/er or the heirs to enforce collection by suit within such period. She/he should also seek legal and accounting advice on how long to retain the financial records of her/his late spouse. It is quite possible that his/her estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

A widow/er should consult her/his attorney as to whether the estate needs to arrange a malpractice policy buy-out with the deceased physician's carrier so as to protect the estate assets and the widow/er's share of such assets. Some physicians will have attempted to do this during lifetime and if they did so this will be evident from study of the policy, its endorsements and correspondence. If there is uncertainty in the matter, the attorney should contact the insurance carrier and seek its cooperation in ascertaining the facts. The reason for this is that a suit can be maintained against the estate and heirs of a deceased physician who is alleged to have committed one or more acts of professional negligence with resultant injury to a patient.

The State Medical Society office is always available for consultation with a widow/er, the family, or the estate attorney. ■

HAVE YOU BEEN CALLED LATELY?

or, What's the Latest on the Patients Compensation Panels?

In 1975 MANDATORY pretrail screening panels were legislated. See article in June 1978 Blue Book, page 41, "You Are Being Sued for Malpractice, or What the Physician Should Know About Malpractice Litigation," for a description of the panel process. A pamphlet including information on the Patients Compensation Panels is also available from the State Medical Society's Physicians Alliance on request, "So You've Been Sued . . . Now What?"

Do I have to serve as a panel member if I am called?

Yes, by law, unless the administrator of the panels excuses you for "good cause." *Good cause* is interpreted as meaning: (1) a conflict of interest, (2) a schedule conflict, such as operative, emergency, out of the state or country, or a pre-arranged lecture series, etc, (3) strong moral, ethical or religious beliefs, and (4) if the medical issue is one with which the physician is not familiar.

How much of my time will be required?

Physicians are appointed to the Formal Panel (5-members) for a period of six months. Physicians also may be appointed to the Formal Panel, as well as the Informal Panel (3-members) on a case-by-case basis. You will be expected to review the specifics of the case, such as medical records, depositions, etc, before the panel hearing. These records are usually sent two to four weeks prior to the hearing date. The physician panel member also may be asked to alert the panel of other medical experts who should be consulted. The hearing, with all parties present, averages two days. Informal Panels usually take one day, plus the panel deliberation of approximately 3 to 5 hours. Formal Panels are often longer; four days may be required. In Milwaukee, meetings are held evenings or weekends if possible. You may be required to travel to another city for the hearing.

What if I don't want to serve on the panel?

The Panel Administrator (through the Supeme Court of Wisconsin) does have sanction applicable to civil actions (Formal Panels) and could hold a physician in contempt for non-appearance or tax the physician for the costs of the panel hearing. However, both the State Medical Society and the Panel Administrator are interested in maintaining a positive atmosphere in this relatively new approach to resolving professional liability disputes. The Society urges a cooperative attitude. And to date, results are encounaging. As of January 1980 only 5% of approximately 225 cases have been filed in court subsequent to a panel determination.

What compensation will I receive for my time?

As a panel member, you will be paid $75 per day for attendance at the hearing, plus travel expenses. Panels can call their own expert witnesses, if this is necessary in addition to panel expertise. Expert medical witnesses are paid according to their regular fee-for-service. While the availability of this medical expertise has been viewed by some as a relatively inexpensive "fishing expedition" for attorneys and their clients, sometimes this second medical opinion settles the issue to the patient's and attorney's satisfaction.

Why me?

Who else? If you would like more information. call or write the SMS Physicians Alliance, PO Box 1109, Madison, WI 53701; telephone toll-free: 1-800-362-9080, or 257-6781 for Madison area.

MEDICOLEGAL FIRST AID

THE CONTINUING AND RAPID scientific advances coupled with the increased demands and expectations of patients frequently results in an imbalance between the art and science of medicine. A proper blending of the art and science by the practicing physician and his associates contributes much in the way of patient and professional satisfaction. It appears that the professional liability insurance market is less restricted in Wisconsin than it is in several other jurisdictions. Even so, SMS members are required to pay substantial premium rates for this protection which is so essential to the practice of medicine. The following points in this important area are offered to physicians.

I. Keep your expired professional liability policies

Comment: The Statute of Limitations has been revised to allow actions involving adults to be initiated within three years of the occurrence or one year from discovery of the injury but not later than five years from the occurrence. Actions involving minors are bound by this limitation, or age 10 years, whichever is later. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

II. Keep good records and retain them for years

Comment: See Comment to No. I. In any event retain records in *all* cases for a minimum of six (6) years after date of last treatment. As to the special situations presented by minors and the mentally ill or incompetent, see your personal attorney.

III. Advise patients as to risk involved in not only operative procedures, but also as to side effects of drugs prescribed or administered; this is frequently called "Informed Consent"

Comment: The legal test appears to be "What would the average prudent person in the patient's position have decided if informed of the perils?" No longer is the legal test what the *physician* believes the patient or his representative should know about the risks of the patient.

IV. The "Locality Rule" has been abolished in Wisconsin

Comment: The practitioner be he "generalist" or "specialist" is now subject to liability in an action for negligence if he fails to exercise that degree of care and skill which is exercised by the average practitioner in a class to which he belongs, acting in the same or similar circumstances. Geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate.

V. Continued membership in your Society is recognized by the Courts as vital for continuing education

Comment: The Courts state that there is no lack of opportunity to keep abreast of the advances made in the medical profession and cites the AMA JOURNAL as authority. The same reasoning applies to SMS JOURNAL and the Society's continuing education programs.

VI. Refrain from ill-advised remarks; THINK BEFORE YOU SPEAK

Comment: Many of the malpractice cases have their genesis in the unfortunate thoughtless spontaneous statements of a nurse, a technician or a physician. Warn your employees and assistants to be on the alert at *all* times.

VII. Give prompt notice to insurer in the event of an "incident"

Comment: Should there be any occurrence in the patient-physician relationship which might result in either a claim or litigation, give prompt notice to the carrier. Timely notice and prompt investigation are far superior to waiting for a formal summons.

VIII. Provide Continuity of Care

Comment: Once a physician accepts a patient which requires a course of treatment he should pursue the plan of prescribed care. If the physician is to be out of the area for an extended period he should arrange for suitable coverage and so notify the patient. Should the patient fail to complete the prescribed plan of care, the physician should follow-up and; in either event this should be documented in the patient's record.

IX. Be alert to the suit-prone "litigious" patient

Comment: Some patients have a tendency to be hypercritical of physicians who have previously treated them. Others may have unrealistic expectations of good or perfect results of medical care. In such situations, extreme caution should be exercised so as to minimize the probability that you or a physician who has treated the patient previously will become involved in a liability claim or suit.

X. Avoid discussion of your liability insurance

Comment: The knowledge that you carry insurance *may* precipitate a claim should an unanticipated complication arise or if the patient becomes dissatisfied with the results of a course of treatment.

XI. Always exercise discretion in the collection of account

Comment: All patient accounts should be reviewed be fore being turned over to a collection agency, and specia consideration should be given to the accounts of patient who have evidenced any degree of dissatisfaction whicl might become the basis for a counter charge in the forn of a suit against the physician. While the physician is en titled to remuneration for professional services rendered foregoing payment may be less of a loss than being defendant in a lawsuit.

XII. Avoid direct contact with a plaintiff's attorney

Comment: In the event of a claim or suit and th plaintiff's attorney attempts to contact you, you are we advised to refer him to your own attorney. Any com munication you may have with a plaintiff's attorney – no matter how well intentioned — might very well com promise your defense if the case proceeds to litigation.

XIII. You are responsible for the acts of technicians an assistants in your employ

Comment: Be sure that your insurance covers you fo any liability arising from their acts or omissions.

XIV. Insure your corporation or partnership

Comment: A patient may sue both a physician and h corporation or partnership so make sure it is properly in sured.

The AMA House of Delegates approved the *Guidelines for Prescribers of Controlled Substances* at its Interim Meeting in December 1979 after the Board of Trustees recommended endorsement. The Drug Enforcement Agency (DEA) and its Practitioners' Working Committee, of which the AMA is a member, developed these suggested principles for good prescribing practices to "provide a common-sense approach to encourage voluntary compliance by the prescribing professions." Other members of the Committee are the American Dental Association, American Nurses Association, American Osteopathic Association, American Podiatry Association, American Veterinary Medical Association, and the National Institute on Drug Abuse. The AMA Board of Trustees has described the guidelines as "intended to remind practitioners of the potential of controlled substances for drug abuse and dependence, without being restrictive in any sense of the physician's prerogative to prescribe as he sees fit in the best interests of his patients."

Guidelines for prescribers of controlled substances

A Joint Statement of the Drug Enforcement Administration and the DEA/Practitioners Working Committee

THE FOLLOWING embodies the collective thinking of members of the DEA/Practitioners Working Committee. First formed in 1974, this Committee has provided a forum for DEA officials and association executives and practitioners to meet voluntarily to discuss items, issues, and subjects of mutual interest, areas of practical concern, and generally maintain an open and responsive attitude among the various members. Having no intrinsic authority, and seeking none, the DEA/Practitioners Working Committee believes it has played a significant role in promoting the generally harmonious relationships which exist between its national organizations and their respective members. It is against this background of shared experience and knowledge that participants in the work of this Committee offer these "Guidelines for Prescribers of Controlled Substances" to members of the professions throughout the country.

Purpose

The purpose of this joint statement and the presentation of guidelines is to provide and establish acceptable professional responses to the demands of the Controlled Substances Act. The guidelines provide a common sense approach to encourage voluntary compliance by the prescribing professions.

General Statement

The principles expressed in these guidelines constitute neither a pronouncement of law nor a code of ethics, and are not intended to in any way supersede or be in conflict with statutes or ethical concepts governing the conduct of the various practitioners in their respective practices or in their respective professional organizations. Accountability is the responsibility of each discipline.

Application of State and Federal Law

Separate laws relating to the distribution of controlled substances have been enacted in most states. In many cases state law is much more stringent than Federal law and will not allow certain practices which may be authorized under Federal law. The guidelines are an example of good practices which should be encouraged under both Federal and state laws and regulations. Close cooperation and understanding between law enforcement and medicine will ensure that legitimate drugs remain in legitimate channels.

Communication

Recognizing that members of each profession have special competencies and knowledge concerning drugs and related therapeutic agents, a free exchange of information on these matters is encouraged among the professions at all levels.

General Guidelines

- Controlled substances have legitimate clinical usefulness and the prescriber should not hesitate to consider prescribing them when they are indicated for the comfort and well being of patients.
- Prescribing controlled substances for legitimate medical uses requires special caution because of their potential for abuse and dependence.
- Exercise good judgment in administering and prescribing controlled substances so that diversion to illicit use is avoided and the development of drug dependence is minimized or prevented.
- Guard against contributing to drug abuse through injudicious prescription writing practices, or by acquiescence to unwarranted demands of some patients.
- Each prescriber is asked to examine his/her individual prescribing practices to ensure that all prescription orders for controlled substances are written with caution.
- Make specific effort to ensure that multiple prescription orders are not being obtained by the patient from different prescribers.

Guidelines—Prescription Orders

The prescriber is granted through legal authority the right to prescribe medications that are necessary for the proper treatment of his/her patients. Prescribing is governed by laws and regulations which set minimum standards and requirements. These guidelines, tempered with good moral and ethical considerations, give guidance to going beyond the minimum requirements.

- The prescription order must be signed by the prescriber when it is written. The prescriber's name, address, and DEA registration number and full name and address of the patient must be given when prescribing controlled substances.

continued on next page

- The written prescription order should be precise and distinctly legible to enhance exact and effective communications between prescriber and dispenser.
- The prescription order should indicate whether or not it may be renewed and, if so, the number of times or the duration such renewal is authorized.
- Prescription orders for drugs in Schedules III, IV, and V may be issued either orally or in writing and may be renewed if so authorized on the prescription order. However, the prescription order may only be renewed up to five times within six months after the date of issue.
- A written prescription order is required for drugs in Schedule II. The renewing of Schedule II prescription orders is prohibited. Only in an emergency situation may oral orders for Schedule II drugs be accepted by a dispenser.
- Controlled substances which are prescribed without indication for renewal cannot be renewed without authorization by the prescriber.
- Prescribe no greater quantity of a controlled substance than is needed until the next check-up.
- Try to make prescription orders alteration-proof.
- When prescribing a controlled substance, write out the actual amount in addition to giving an Arabic number or Roman numeral in order to discourage alterations in written prescription orders.
- Prescribers are encouraged to consider placing a number of check-off boxes on their prescription blanks which show amounts within which the prescribed amount falls, *i.e.*, 1-25, 26-50, 51-100, over 100.
- Use separate prescription blank for each controlled substance prescribed.
- The use of prescription blanks which are preprinted with the name of a proprietary preparation should be discouraged
- When institutional prescription blanks are used, the prescriber should print his/her name, address, and DEA registration number on such blanks.
- Institutions should discourage the use of institutional prescription blanks for prescribing controlled substances. The prescriber should use his/her own prescription blanks in such instances.

Duty to Inform

The prescriber has the responsibility to inform patients of the effects of the prescribed drugs consistent with good medical practice and professional judgment. The patient has a corresponding duty to comply with the prescriber's directions for use of the prescribed medication.

Each of the professional organizations and the Drug Enforcement Administration has a responsibility to educate and inform the public on proper handling and use of controlled substances. The professions represented on the DEA/ Practitioners Working Committee recognize that they have responsibilities to themselves, beyond legal minimum restraints. ■

NARCOTICS

Annual Registration

A physician who desires to dispense, administer, or prescribe any controlled drug substance is required to have a Drug Enforcement Administration number (DEA no.). The initial registration application may be obtained from the Chicago Regional Office. The Regional Office of DEA in Chicago has informed the State Medical Society that DEA Headquarters will then annually mail a renewal application to each physician once initially registered.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC, 20005.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, P O Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Preprinted Prescription Blanks

The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

STATEMENT

Re: Prescribing habits with benzodiazepine class of drugs

Prepared by the Committee on Alcoholism and Other Drug Abuse of the State Medical Society of Wisconsin and approved by the Society Council, May 17, 1980

The benzodiazepines are among the most widely prescribed drugs in the United States. Their safety and efficacy have been heretofore unparalleled among the sedative hypnotic drugs. However, new evidence is appearing with increasing frequency in the literature that long-term benzodiazepine use (four to six months) has the potential to cause physical and psychological dependence. A withdrawal syndrome, which may feature anorexia, insomnia, agitation, hypertension, and tachycardia, has been documented in numerous patients—which syndrome is not to be confused with the condition for which the drug was originally prescribed. In addition, seizures and hallucinations have been reported upon abrupt cessation of even therapeutic doses of benzodiazepines.

There is evidence in one study, that benzodiazepines are prescribed for women twice as often as men. We urge physicians to rethink their experiences with benzodiazepines in light of the new evidence that associates long-term use with major withdrawal sequelae.

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*The references are to be considered a part of the statement.

Rule on prescribing, dispensing of amphetamines

EFFECTIVE NOVEMBER 1, 1977 virtually all sales and prescriptions of amphetamines were banned in Wisconsin in an action taken by the State Medical Examining Board. This action is found in Chapter Med 10.02(2) (s) of the Wisconsin Administrative Code. It includes only certain Schedule II controlled substances. The rule reads as follows:

UNPROFESSIONAL CONDUCT DEFINED

Med. 10.02(2) (s) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine, sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of ch. 161 Wis. Stats. to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun.

(INFORMATIONAL NOTE: The following list, although not exhaustive or exclusive, does include most of the brand-name drugs available in the United States as of March 1, 1978, which fall within the definition of ch. 10.02(2)(s): Benzedrine, Biphetamine, Delcobese, Desoxyn, Dexamyl, Dexedrine, Eskatrol, Fetamin, Obetrol, Obotan, and Preludin).

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and in 8 ml. multiple-dose vials,
both in packages of 10.
SK&F LAB CO.
a SmithKline company
Tagamet
brand of cimetidine
Tablets
100 tablets
NDC 0108-5013-20
2 ml. = 300 mg.
Tagamet
(cimetidine HCl)
300 mg. cimetidine/2 ml.
SKF
T13

Alpha Stimulation

Central Control of Blood Pressure*

"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

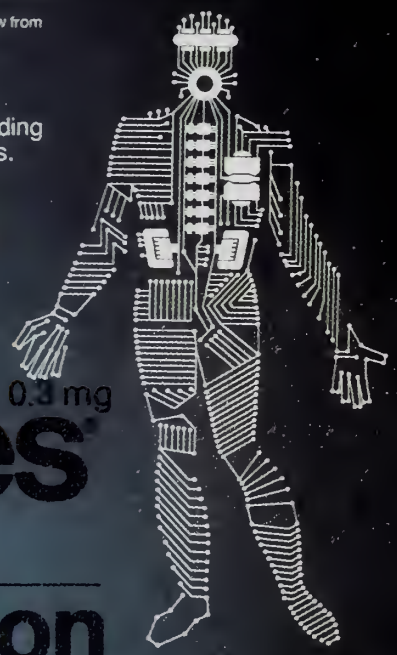
Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1 Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.



Now available in new 0.3 mg tablets

Tablets of 0.1, 0.2, 0.3 mg

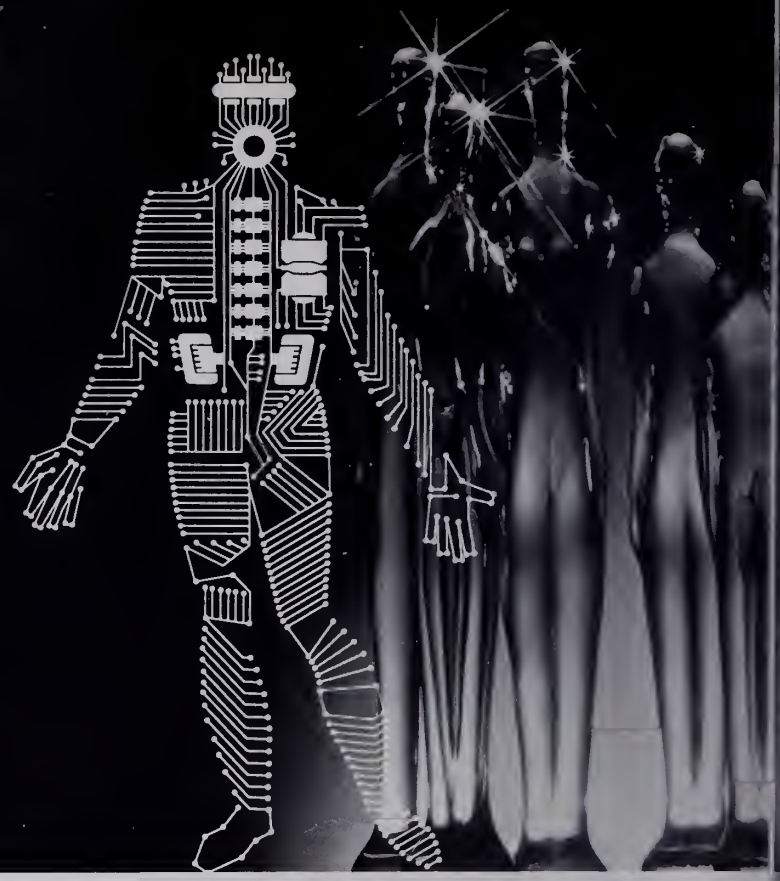
Catapres®

(clonidine HCl)

Hypertension

The Alpha Advantage:

It's for all kinds of hypertensives



Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at fast and 0.1 mg at bedtime. Some patients may b from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employe

For optimal results, the dose of Catapres must b adjusted according to the patient's individual blo pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated to longer.

Adverse Reactions: The most common reactions are dry mouth, dro sedation. Constipation, dizziness, headache, and fatigue have be Generally these effects tend to diminish with continued therapy. T reactions have been associated with the drug, some of them rare instances an exact causal relationship has not been established.) Th Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abn liver function tests; one report of possible drug-induced hepatitis wi and hyperbilirubinemia in a patient receiving clonidine hydrochl thalidone and papaverine hydrochloride. Weight gain, transient eleva glucose, or serum creatine phosphokinase: congestive heart failure phenomenon; vivid dreams or nightmares, insomnia, other behavic nervousness, restlessness, anxiety and mental depression. Als gioneurotic edema, hives, urticaria, thinning of the hair, pruritus no with a rash, impotence, urinary retention, increased sensitivity to alco itching or burning of the eyes, dryness of the nasal mucosa, pallor, g weakly positive Coombs' test, asymptomatic electrocardiographic a manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, dimi sent reflexes and vomiting followed the accidental ingestion of Catap hydrochloride) by several children from 19 months to 5 years of lavage and administration of an analeptic and vasopressor led to covery within 24 hours. Tolazoline in intravenous doses of 10 mg intervals usually abolishes all effects of Catapres, (clonidine hydroc dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is availab (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 a available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

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Ridgefield, CT 06

Cost containment in your medical practice

THE BROWN COUNTY Medical Society's Cost Containment Committee, chaired by Jeremy R Green, MD, Green Bay, recently developed a plan recommending 65 cost-saving measures that affect doctors, nursing homes, patients, hospitals, and pharmacies. While encouraging its own members to implement the recommendations, the Brown County Medical Society has been cooperating with the State Medical Society in sharing its list with other state physicians. The list follows:

* * *

1. Be cost conscious.
2. Learn item by item the cost of everything you do. Patient's hospital bills will be sent to you periodically. Study them. Find out how many healthcare dollars you trigger in a single day of practice by keeping a diary of the estimated cost of every patient care action taken that day.
3. Compare your office costs with hospital costs before ordering inpatient or outpatient tests.
4. Discourage annual physical examinations under the age of 60 years.
5. Discourage "super" physical exams with routine SMAs, EKGs, chest x-rays. Critically evaluate usefulness of routine pap smears, proctoscopies, electrocardiograms, treadmills, etc.
6. Encourage and utilize physician extenders, nurse practitioners, and physician's assistants.
7. Encourage home visits by physician extenders.
8. Anticipate student physical examinations. Combine camp, school, and athletic physical exams.
9. Aggressively seek alternatives to hospitalization—home health care, extended care, nursing home.
10. Avoid hospitalization for observation, overnight rest, diagnostic studies. Decrease incentives for hospitalization.
11. Learn what physical therapy, occupational therapy, respiratory therapy, social services, medical photographers, dieticians and other auxiliary services do and cost so as to order tests appropriately.
12. Curb unnecessary surgery.
13. Reduce postoperative stay in hospital—encourage earlier home and office follow-up visits.
14. Learn the cost of emergency room procedures.
15. Discourage the use of emergency room for minor or nonurgent ailment. Discourage crisis care.
16. Discourage excessive use of laboratory and x-ray procedures in the emergency room.
17. Avoid late-in-the-week hospitalization.
18. Do initial lab work and x-rays in the office or as an outpatient before admission.
19. Decrease the use of critical care units. Be highly selective in admitting to critical care. Reduce stays in coronary and critical care units. Critically evaluate neonatal intensive care units.
20. Have hospital accounting personnel post up-to-the-minute bills in long-term critical care cases.
21. Encourage and utilize one-day care units. Consider "morning-of-surgery" admissions.
22. Have hospital social service evaluate patients who will probably need extended care shortly after admission rather than at the end of their stay.
23. Discourage further construction of hospitals or extension of existing hospitals unless proven absolutely necessary.
24. Encourage hospitals to appoint resource allocation board with physicians and administration so as to have input with all major building programs, expansion, equipment purchasing, new programs, etc.
25. Urge hospitals to critically evaluate their employee/patient ratio. Challenge them to reduce number of employees.
26. Encourage the reduction of unused beds and even the closure of wings if underutilized.
27. Discourage hospital competition for expensive services.
28. Urge hospitals to share purchasing services, promote and reward efficiency, develop incentives for employees to cut costs.
29. Have each hospital appoint a cost containment committee as part of the staff to review and follow up ways of containing costs.
30. Be less reliant on laboratory tests. Be more deliberate and thoughtful about ordering each test. Make every effort to reduce the number of lab tests and x-rays ordered.
31. Curb tendency to order panels or profiles and to prove the diagnosis over and over. Discourage routine lab tests.
32. Avoid sending unnecessary specimens to pathology.
33. Exploit opportunities to have tests done on an outpatient basis at the least expensive hospital.
34. Encourage hospitals to provide services seven days a week rather than on weekdays only or certain specific days.
35. Examine critically your prescribing habits.
36. Learn the cost of the common drugs you use and know if savings on substitute items.
37. Prescribe generic drugs.
38. Suggest over the counter drugs whenever possible—antihistamines, decongestants, antibiotic ointments, motion sickness tablets, etc.
39. Prescribe by package size.
40. Urge pharmacies to publish a list of their drug prices.
41. Curb fee increases, reduce fees on common, frequently performed procedures.
42. Encourage legislation to have deductible on insurance.
43. Encourage specialty groups to get together to discuss ways of curbing costs.
44. Obtain price list of standard radiology, pathology, lab and other fixed patient-care charges.
45. Know consultant fees.
46. If several physicians are on a case, define responsibility of each physician—who is primary MD, who will charge for visit and procedure, who will order tests.
47. Referrals are costly. Avoid referrals unless absolutely necessary, particularly in chronic insoluble problems.
48. Encourage informal hallway consultations.
49. Always send letter, lab and x-ray results with patient when referring so as to prevent duplication of tests.
50. Be sure covering colleagues have access to your records to prevent unnecessary hospitalization, duplication of tests, etc.
51. Discourage further construction of nursing homes and extension of these unless proven absolutely necessary.

52. Obtain copies of nursing home bills and drug charges regularly.
53. Know the cost of therapy and other auxiliary services in nursing homes and insist on regular reports from them.
54. Educate patients in healthcare cost—dispel the attitude that most expensive is the best.
55. Explain that hospitalization is the largest component of healthcare cost. Discourage hospitalization whenever possible.
56. Educate patients on the cost of lab, x-rays, prescriptions, and the cost-effectiveness of these.
57. Educate patients to take care of minor ailments themselves and become less dependent on physicians.
58. Refuse to be pressured into services that are covered by insurance and are therefore "free."
59. Institute patient education aids—tapes, printed materials.
60. Institute and encourage preventive healthcare p grams—diet, exercise, smoking, drugs, alcohol, s belts, motorcycle helmets, environmental polluti monitoring TV programs for children.
61. Encourage patients to shop around for family phar cists and to discuss costs of drugs with him.
62. Refuse to prescribe unnecessary medications and unnecessary tests.
63. Encourage patients to get second opinion where r essary to reduce unnecessary surgery.
64. Have patients know the names and major side effect all the drugs they take.
65. Discourage the unnecessary buying of health foods, amins, minerals, tonics, quack remedies, and other s posed health aids. ■

"The single most important factor influencing the extent of improvements which occurred in these jails' health c systems was the amount of support and cooperation received from the medical community, whether inside or outs the facilities . . . The most important external factor seemed to be related to the amount and type of technical assista provided by medical society State Project Directors." —AMA, Study and Analysis Report on *Program to Impr Medical Care and Health Services in Jails,* June 1979

Jail health care in Wisconsin

ONE OF THE greatest fears many prisoners have the first time they are jailed is: What if I get sick? Will anyone help me?

* * *

In 1976, SMS was one of six medical societies chosen by the AMA to participate in a pilot project to improve the delivery of health services in county jails. There are now a total of 23 participating state societies which are funded on a yearly basis by the Law Enforcement Assistance Administration. Each society contributes about 10% of the costs.

A Supreme Court decision in 1972 decreed that lack of adequate medical care for prisoners violated their constitutional rights. Therefore, the first order of business for the AMA was to develop standards defining "adequate" and to test these standards in county jails.

Thus far, the sheriffs of 28 Wisconsin counties h asked for help from SMS and 9 jails have been accred by the AMA. A substantial number of improvements h been made in all 28 jails. Technical assistance from S emphasizes using existing community resources, sucl the county nursing service and mental health and a holism counselors from the Unified Services Board.

Sheriffs volunteered to participate in this project cause it proved to be not only humanitarian but cost-effective. In addition, at least three medically rel lawsuits never materialized when the lawyers discov the jails were accredited and that appropriate care been given to their clients.

Is your county jail participating? Can you help sheriff formulate an adequate delivery system?

16 COUNTY JAILS ARE PARTICIPATING IN THE WISCONSIN JAIL HEALTH CARE PROJECT:

Eau Claire	Columbia	Pierce	Walworth
Milwaukee	Dodge	Racine	Washington
Adams	Dunn	Rock	Winnebago
Dane	Green	St Croix	Waukesha

In addition to the jails listed above, the following additional counties are participating in the program: Brown, Clark, Grant, Iowa, Juneau, Kenosha, Manitowoc, Milwaukee House of Corrections, Ozaukee, Polk, Sheboygan, and Wood.

Is your county jail or county one of them? If not, would you like to recommend that they participate? To do so, please contact the State Medical Society of Wisconsin, Attention Parks Reinhardt, PO Box 1109, Madison, Wis 53701; or phone toll-free 1-800-362-9080.

"The professionals showed me how sound planning can cut my estate taxes."

"I didn't want my family penalized with needless taxes and unnecessary probate expenses. So I talked to the professionals at First Wisconsin. Working with my attorney, they put together a plan that offers maximum tax savings, reduced management costs and potential for greater estate earnings.

That's why when that time comes, my family will benefit from experienced planning that minimizes taxes and protects them against financial set-backs. That's worth a lot to me — knowing that nothing has been left to chance."

We'd like you to know more about First Wisconsin financial planning and investment services and how they can save you dollars and worry. With offices located throughout the state of Wisconsin, call one of our professionals located closest to you.

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Milwaukee, Wisconsin 53202
(414) 765-5080

James N. Effland, Vice President
First Wisconsin Bank of Green Bay
425 Pine Street
Green Bay, Wisconsin 54305
(414) 432-0321

James E. Sugar, Vice President
First Wisconsin National Bank of Madison
First Wisconsin Plaza
Madison, Wisconsin 53707
(608) 252-4250

Wilson K. Roane, Vice President
First Wisconsin National Bank of Oshkosh
111 North Main Street
Oshkosh, Wisconsin 54903
(414) 424-4200

James P. Johannsen, Assistant Vice President
First Wisconsin National Bank of Eau Claire
131 South Barstow Commons
Eau Claire, Wisconsin 54701
(715) 835-3111

FWT-2D9R2

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to tir adopt, alter and enforce constitution, bylaws and reg lations for the admission and expulsion of membe election of officers, and management, not inconsiste with the constitution, bylaws and regulations of the st society.

148.03 Service insurance corporations for health ca The state medical society or, in a manner approved the state society, a county society, may establish in o or more counties of this state a service insurance corpo tion for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450. Chapter 613 provides in general terms for the creati governance and regulation of service insurance corpo tions for any kind of health care, as well as for otl types of services. All that is needed in each authoriz chapter for professional societies is a brief section giv the appropriate professional society the power to ganize a ch. 613 corporation. Section 148.03 crea that section for health care.

One basic restriction results from the repeal of old enabling sections: none of the professional societ will be able to organize a service insurance plan wit its own corporate structure. It is a mistake to pen such a mixing of professional and insurance activi within the same corporation. The society can, of cou control the service insurance corporation it creates un ch. 613, but the service insurance corporation will legally separate. This will lead to more effective (appropriate) control by the insurance commissior who should neither be empowered nor compelled, arguably he was under the old statutes, to have concern about the purely professional activities of societies, because of the impossibility of disentangl the insurance and professional activities carried on b single corporation.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius L. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

THE CURRENT CONSTITUTION AND BYLAWS AND THE PROPOSED GENERAL REVISION OF THE CONSTITUTION AND BYLAWS APPEAR ON THE FOLLOWING PAGES.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to bring into one compact organization the entire medical profession of the state of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote open communication and understanding among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors, immediate past president, president, president-elect, speaker and vice-speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Council, but without the right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members, and in March 1976 to add the president-elect and vice-speaker. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION I. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for

*COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through April 1978.

which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from eight districts, and a speaker and vice-speaker of the House of Delegates.

Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the approval and confirmation of the House of Delegates.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph; second paragraph amended in March 1973. Number of districts reduced from thirteen to eight in April 1975.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the eight districts, except that in any councilor district embracing a membership of 200 or more, there shall be elected one additional councilor for each additional 200 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965. Number of members used as basis for councilor representation changed from 250 to 200 in April 1975.

As nearly as possible, one-third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thi vote, order a general referendum upon any question pend before the House of Delegates. The House of Delegates m by a vote of its members, submit any question to the memb ship of the Society for its vote. A majority vote of all the me bers of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to cha or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this C stitution by a two-thirds vote of the members of the Ho present at any annual session, provided that such amendm shall have been presented in open meeting at the previous nual session, and that it shall have been published twice du the year in the bulletin or Journal of this Society, or sent cially to each component society at least two months before meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roste this Society, after it has been properly reported by the secret of his county society shall be *prima facie* evidence of memb ship and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspensior expulsion from any component society of this Society, whose name has been dropped from its roll of members, sl be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual sess shall register, when his right to membership has been veri by reference to the records of this Society. No member sl take part in any of the proceedings of the annual session u he has complied with the provisions of this section of Bylaws.

SEC. 4. Each county society shall judge of the qualificati of its members, subject to review and final decision by Council of the State Society. Every reputable and legally qu ified physician, who holds a license to practice medicine surgery, and whose principal practice is within the same cou shall be eligible to apply for membership so long as he d not practice nor profess to practice sectarian medicine, or gage in practice in a manner in conflict with the Principle Ethics of the American Medical Association, or so cond himself as to defeat the purposes for which the Society is ganized and is operating. By proper provision of Constitu and Bylaws, either or both as may be necessary, the county ciety may require of an applicant for membership that he sl have practiced within the jurisdiction of the society to wh he is applying, for a period of one year as a condition preced to election to membership; or the county society may prov that an applicant for membership first may be elected to me bership for a term of only one year, with the provision that s

embership shall then terminate, and the member resubmit to ection, without limitation as to term, by vote of the Society.

A member of a component society whose license has been voked, suspended, or voluntarily surrendered, shall be opped from membership automatically as of the date of revatic~, suspension, or voluntary surrender. The Council of e State Society shall have final authority to expel a member ould a component county society fail to do so after being so quested by the Council.

A physician's county society membership must be held in at county in which his principal practice is located. However, physician living near a county line may hold his membership that county most convenient for him to attend meetings, on rmission of the component society in which county he mainins his principal place of practice.

A member who removes his principal practice from within e territorial limits of a component medical society in which holds membership, to the territory of another component of e State Society, shall not be eligible to continue his memberip in the first such society after the expiration of the calendar ar in which such removal shall have occurred. Such member all, however, be eligible to apply for membership anew, or transfer to the society in whose jurisdiction his principal actice shall have been removed.

By proper provision of Constitution and Bylaws, either or th as may be necessary, a county society may admit to memrship those in training as hospital residents or as research felws who are licensed to practice medicine and surgery in the ite of Wisconsin, provided that any applicant so elected shall t be permitted such membership beyond a period of five ars from the date of such election. Such resident members all have the right to vote and hold office.

Sec. 5. When a member in good standing in a component unty society moves to another county in this state, he shall given a written certificate of these facts by the secretary of society, without cost, for transmission to the secretary of the ciety in the county to which he moves. Pending his acceptce or rejection by the society in the county to which he reves, such member shall be considered to be in good standg in the county society from which he was certified and in the ate Society to the end of the period (respectively) for which dues have been paid.

When a member in good standing in a component society moves his principal practice outside the borders of this State, may continue his active membership in such component soety and in the State Society by fulfilling all requirements of embership except residence pending his acceptance as a new transfer member by the society of the area to which he has nsferred his practice. Except as otherwise provided in Secn 14 of this Chapter, the period of such continuing memberips in this State shall cease upon his acceptance by a society the new area of practice, and shall in no event continue end two full calendar years after that in which he transferred e location of his practice.

Sec. 6. This Society shall recognize as a special service mber any physician who is in the armed forces of the United ates, who has been licensed to practice medicine and surgery Wisconsin, and who has not previously been a member of y county medical society. Such physician shall first have en accepted as a special service member by a component unty society in accordance with the provisions of its constiion and bylaws, and the fact of such membership certified to s Society. Application for such special service membership all not be dependent upon the place of previous residence or place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member during term of service or for the balance of the year following separation from active duty. Special service membership shall lapse at the close of the calendar year of the separation of each such member from active duty.

Sec. 7. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

Sec. 8. *Honorary Membership.* Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

Sec. 9. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

Sec. 10. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, or who practices less than six (6) weeks per year, is eligible for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

Sec. 11. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

Sec. 12. *Military Service Membership.* Members who are inducted into active United States military service shall be granted military service membership. Dues for such member are waived during term of service and for the balance of the year following separation from active duty.

Sec. 13. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the *Wisconsin Medical Journal,* and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

Sec. 14. *Nonresident Membership.* Any member who moves

to the jurisdictional area of another constituent association, while in dues-paid status, may be granted nonresident membership upon written request to and approval by the Council. A nonresident member shall have all the rights and privileges of regular membership except the rights to vote and hold office. This nonresident category shall require no involvement of a county medical society. Neither the time limit in paragraph 2, Section 5 of this Chapter nor the provisions of Chapter VIII shall apply to this Section. The annual dues shall be established by the Council.

SEC. 15. *Senior Membership.* Any member who has reached age 65 and practices 1,000 hours or less during a calendar year, but does not qualify for associate membership, may upon application, recommendation by the county medical society, and approval by the State Medical Society, be granted senior membership upon payment of 50% of regular member dues. Such change shall be effective January 1 following receipt of such request.

COMMENT: Section 13, added in May 1964; sections 14 and 15, in April 1978.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

COMMENT: Section 2 on publication of scientific papers rescinded in May 1972.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966; second paragraph of Section 2, below, amended in March 1973.

The term "full-paid members" as used in this section includes regular members of the Society, life members, affiliate members, associate members, educational members, resident members, honorary members, special service members, and members whose dues are waived or remitted by official action of the Society. Members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such de egates are elected to serve. Representation in the House of De egates shall be contingent on compliance with the foregoi provision.

SEC. 3. One-fourth of the members of the House of Del gates registered, representing one-fourth of the county medic societies in the state, shall constitute a quorum of the House Delegates. All meetings of the House of Delegates shall l open to members of the Society.

SEC. 4. From among members of the House of Delegat the speaker of the House of Delegates, for the purpose of e pediting proceedings, shall appoint Reference Committees which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

He shall also appoint such other committees as may be co sidered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to t House of Delegates of the American Medical Association accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state in councilor districts, specifying what counties each district sh include, and, when the best interest of the Society and t profession will be promoted thereby, organize in each a distr medical society, of which all members of the compone county societies shall be members.

SEC. 7. The House of Delegates shall have authority to a point committees for special purposes from among memb of the Society who are not members of the House of Delegat Such committees shall report to the House of Delegates, a may be present and participate in the debate on their report

SEC. 8. It shall approve all memorials and resolutions issu in the name of the Society before they shall become effectiv

SEC. 9. Unanimous consent of the House of Delegates sh be required for the introduction of any new resolution or bu ness not filed in proper form with the secretary's office of t Society two months before the first session of the House of D egates. This section shall not apply to new business or resol tions presented by the Council, the constitutional officers, co mittees of the Society or of the House of Delegates, or offic of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at t annual session shall elect a Committee on Nominations co sisting of one delegate for each district, except that in any cou cilor district embracing a membership of 500 or more, th shall be elected one additional delegate for each additional 5 members or major fraction thereof, and one delegate rep senting all of the specialty sections. This newly elected co mittee shall become operative at the close of the final meeti of that annual session, and shall function until the close of t final meeting of the following year's annual session. The i coming committee shall meet with the existing committee, b without vote, during the overlapping days of the annual s sion. The Committee on Nominations shall report the result its deliberations to the House of Delegates in the form o ticket containing the names of one or more members for ea

the offices to be filled at the next annual session. No two ndidates for president-elect shall be from the same district.

The Committee on Nominations shall convene at least two onths prior to the annual session of the House of Delegates prepare a slate of candidates. This meeting, to be held at the ociety headquarters, shall include an open session of not less an one hour to allow individual nomination of candidates. ny vacancy occurring in the Committee on Nominations be- een the date of its election and the time of its reporting shall filled by appointment by the councilor or councilors of the uncilor district in which the vacancy occurs; provided that if e vacancy occurs in the representation from the specialty sec- ons, such vacancy shall be filled by ballot of the several sec- on chairmen.

COMMENT: Section 1 amended in March 1973; first sentence of par- raph one further amended in April 1975; section further amended in arch 1976.

SEC. 2. The report of the nominating committee and the ection of officers shall be the first order of business of the ouse of Delegates at the third meeting of the House.

SEC. 3. The House of Delegates shall elect the president- ect, speaker and vice-speaker of the House of Delegates, and legates and alternates to the American Medical Association. here there is no contest, a majority vote without ballot shall ect. All other elections shall be by separate ballot for each dividual position, and a majority of the legal votes cast shall necessary to elect. In case no nominee receives a majority of e votes on the first ballot, the nominee receiving the lowest mber of votes shall be dropped, except where there is a tie r the lowest number of votes and a new ballot taken This ocedure shall be continued until one of the nominees re- ives a majority of the legal votes cast.

SEC. 4. Nothing in this chapter shall be construed to prevent lditional nominations being made from the floor by members the House of Delegates.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the ciety; he shall appoint a Committee on Arrangements for e annual session and all committees not otherwise provided r; he shall deliver an annual address at such time as may be ranged, and shall perform such other duties as custom and rliamentary usage may require. He shall be the real head of e profession of the state during his term of office, and, as far practicable, shall visit, by appointment, the various sections the state and assist the councilors in building up the county cieties, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his sence or disability. If the office of president should become cant the president-elect shall succeed to the presidency. In se of vacancy in the office of both president and president- ect the Council shall appoint one of its members as acting esident until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the uncil may provide. He shall demand and receive all funds e the Society, together with bequests and donations. He shall y money out of the treasury only on a written order of the cretary; he shall subject his accounts to such examination as e House of Delegates may order, and he shall annually ren- r an account of his doings and of the state of the funds in his nds.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of *Wisconsin Medical Journal).*

In March 1973 the House reaffirmed the above and stated that as general manager, the secretary is in charge of all Society divisions, activities, and personnel.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and

other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the *Journal* and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary a the first meeting of the Council each year. Its chairman sha submit an annual report to the House of Delegates, which sha specify the character and cost of the publications of the Societ the amount and character of all of its property, and shall pro vide full information concerning the management of all affai of the Society which the Council is charged to administer. Th Council may elect a vice-chairman and create such further o fices or combine or abolish them as it sees fit in the manag ment of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacanc in office not otherwise provided for which may occur durin the interval between annual meetings of the House of Del gates; the appointee shall serve until his successor has bee elected and has qualified.

When a councilor district initially qualifies for an addition councilor, such position shall be considered new and not a va cancy to which the Council is authorized to make an interi appointment. Such new position shall be filled by election the next meeting of the House of Delegates in the manner pro vided by Article IX of the Constitution, and the initial ter shall be so established as to maintain the election of substa tially one-third of the councilors each year, as provided in Se tion 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need n be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall b fixed by the Council.

SEC. 10. The Council shall provide such headquarters f the Society as may be required to conduct its business properl

CHAPTER VII

COMMISSIONS AND COMMITTEES

SECTION 1. The Council shall appoint such commissio and committees, either permanent or ad hoc, as it deems ne essary properly to conduct the affairs of the Society. Membe ship on such committees and commissions shall be limited members of the Society and its Auxiliary. Nonmembers wh are eligible for membership cannot be appointed or electe Persons not eligible for membership in the Society or its Au iliary may be appointed as special representatives should the expertise and knowledge be of benefit to the goals of such com mittees or commissions. Such individuals shall not have a vo or the right to hold office.

Each commission and committee shall have the duty keeping currently informed on matters within the area of special interest and activity; of studying the conditions with that area with the purpose of finding possibilities for improv ment; of determining the best solutions it can to the speci matters referred to it; of contributing in its area to the achiev ments of the Society and its members in the protection and i provement of the quality of life for the whole human famil and finally, of making all its efforts useful by passing on to t Society's Council or House of Delegates in the most effecti manner possible the results of its studies and activities with a propriate recommendations for action. In addition, each co mission or committee shall represent the Society's interests continuing contacts with voluntary and governmental agenci having related concerns with a view to coordinated efforts ser ing the best health interests of the people of Wisconsin.

SEC. 2. Specialty sections. The specialty sections shall be garded as special committees of the Society to which the Cou cil or any commission or committee may turn for advice a

sistance on matters of special or general concern to the ofession and the health of the people of Wisconsin. The spe-ilty sections will be expected to give special requests prompt nsideration and response so as to enable the Society to make aximum use of the talents available through these sections d their related specialty societies.

COMMENT: This Chapter repealed and re-created in April 1975; ended in 1978 as to membership.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be deter-ned by the House of Delegates, and shall be levied per cap-on the members of the Society. They shall be payable on or fore January 1 of the year for which they are levied. The sec-ary of each component society shall cause to be collected d shall forward to the offices of the Society the dues and as-ssments for its members, together with such data as shall be quired for a record of its officers and membership. Any ember whose name has not been reported for enrollment and ose dues for the current year have not been remitted to the cretary of this Society on or before March 31 shall be deemed linquent until his name is properly reported and his dues for e current year are properly remitted. The name of any mem-r who has not been reported for enrollment and whose dues r the current year have not been remitted to the secretary of s Society on or before October 15 shall be removed from the tive membership rolls of his county society and this Society til his name is properly reported and all his dues for the year enrollment are properly paid.

An active member in good standing in his county society o has for thirty-five continuous years been a member of this ate Society shall receive a special certificate and plaque in-cating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on e in the offices of the Society shall be final as to the fact of yment by a member and as to his right to participate in the siness and proceedings of the Society and of the House of elegates.

SEC. 3. Any county society which fails to make the reports quired, at least thirty days before the annual session of the ate Society, shall be held suspended, and none of its mem-rs or delegates shall be permitted to participate in any of the oceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the Amer-an Medical Association shall govern members of this Society. o member shall profess adherence or give support to any ex-usive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided herwise in the Constitution and Bylaws, shall be conducted accordance with parliamentary usage as defined in Sturgis andard Code of Parliamentary Procedure.

CHAPTER XI

COUNTY SOCIETIES

SECTION 1. All county societies now in affiliation with the ate Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 4. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 5. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 6. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 6, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC. 7. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 8. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SPECIALTY SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such specialty sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute tl executive committee thereof, and a majority of the executi committee must vote with the majority of the members in o der for any action of the section to be effective. The executi committee shall have the power to appoint such committe within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Socie by any resolution or other action, or to publicize the same, u less the same shall first be approved by the House of Delegate or by a majority of the members of the Council when tl House of Delegates is not in session. No resolution adopted l any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privile of electing a delegate and alternate to the House of Delegate

SEC. 7. The specialty sections of the Society shall be consi ered an integral part of the working committee structure of tl Society as outlined in Chapter VII of these Bylaws.

COMMENT: Section 7 added in April 1975.

CHAPTER XIII

SECTION 1. These Bylaws may be amended at any annu session by a majority vote of the delegates present at that se sion, if the proposed amendment has been properly submitt to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and the Bylaws, all previous Constitutions and Bylaws are therel repealed.

PROPOSED GENERAL REVISION OF THE CONSTITUTION AND BYLAWS

The proposed general revision of the Constitution and Bylaws on the following pages was introduced at the 1980 Annual Meeting of the State Medical Society of Wisconsin by an ad hoc committee, and will be acted upon at the 1981 Annual Meeting, March 26-28. The current Constitution on the preceding pages provides that amendments of that document "shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken."

The Council especially wishes Society members to understand that through its action on this revision, the House of Delegates will once again vote on the "unified membership" issue. The ad hoc committee has, in Article IV, recommended its retention. A two-thirds vote of the delegates will either adopt or amend this or any other Article of the Constitution as presented. Only a majority vote is required to amend the Bylaws.

The Committee to Revise the Constitution and Bylaws was composed of MDs Russell F Lewis, Marshfield; John E Dettmann, Green Bay; Pauline Jackson, LaCrosse; Raymond C Zastrow, Milwaukee; and Albert J Motzel Jr, Waukesha, chairman of the committee and speaker of the House of Delegates during the revision process.

Proposed General Revision

CONSTITUTION AND BYLAWS
of the State Medical Society of Wisconsin

Approved by the Council January 19, 1980

CONSTITUTION	NOTES
ARTICLE I NAME OF THE ASSOCIATION	
The name and title of this organization shall be the State Medical Society of Wisconsin.	No change.
ARTICLE II PURPOSE	
The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws.	Abbreviated.
ARTICLE III COMPONENT SOCIETIES	
Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.	Updated to reflect present-day organization.
ARTICLE IV COMPOSITION OF THE ASSOCIATION	
This Society shall consist of members who shall be the members of and certified by the component county medical societies; who shall also be members of the American Medical Association; and whose dues and assessments for the current year have been received by the Society secretary in accordance with the schedule provided for in the Bylaws.	Slightly reworded; unified membership retained.
ARTICLE V HOUSE OF DELEGATES	
The House of Delegates shall be the legislative body of the Society, and shall consist of: (1) delegates elected by the component county medical societies, (2) one delegate representing each specialty section of the Society organized under the Bylaws, (3) a speaker, (4) a vice speaker.	Clarifies voting membership of House.
The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote.	Defines relationship of speaker and vice speaker to House of Delegates and to individual delegations.
The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty section.	Vice speaker term increased to correspond to speaker's term.

ARTICLE VI
BOARD OF DIRECTORS

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum.

The term "Counci has been changed "Board of Director for greater understan ing of the public a more accurate de nition of the role of t body.

Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district, except that in any district with 200 or more regular and special members, there shall be elected one additional director for each additional 200 members or majority fraction thereof. As nearly as possible, one-third of the members of the Board shall be elected each year.

No other substant change. Some curr provisions are re cated in this Article.

Each director shall be nominated and elected only by the elected delegates of the county medical society or societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates.

The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

ARTICLE VII
SPECIALTY SECTIONS

The House of Delegates shall provide for a division of the Society into specialty sections.

Updated to refl current practice.

ARTICLE VIII
MEETINGS

Section 1. The Society shall hold an annual meeting, at which time the House of Delegates shall meet to conduct its business. The annual meeting may also include scientific sessions as determined by the Board.

Updated to reflect c rent practice.

Sec. 2. The time and place for holding the annual meeting shall be fixed by the Board.

Board authorized to both time and place.

Sec. 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

No change of su stance.

ARTICLE IX
OFFICERS

Officers of this Society shall be a president, a president-elect, a secretary, and a treasurer. The president-elect, secretary, and treasurer shall be elected annually. The president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect. The secretary and the treasurer shall be elected by the Board. The treasurer shall be limited to nine consecutive terms.

Number of positi defined as "office" reduced. Limitation n term of treasu added.

No person shall hold more than one of the following offices concurrently: president, president-elect, secretary, treasurer, speaker, vice speaker, director. Incumbents shall serve until their successors are elected and installed.

ARTICLE X
FUNDS AND EXPENSES

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equally to all members in each class.

Updated to reflect current practices.

All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

ARTICLE XI
REFERENDUM

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

This has been clarified as has often been requested.

ARTICLE XII
SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

No change.

ARTICLE XIII
AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous annual meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

No substantive change.

BYLAWS

CHAPTER I
MEMBERSHIP

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be *prima facie* evidence of membership and of the right to benefits.

This chapter has been edited for purposes of clarification and deletion of extraneous material. There is some relocation and renumbering of current provisions.

Sec. 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an appeal by such person to the Board of Directors.

Sec. 3. Every reputable physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members will conduct themselves in a

Charter Law requirement re license.

manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec. 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitation as to term.

Sec. 5. A member of a component society whose license has been revoked, suspended, nonrenewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, nonrenewal, or voluntary surrender, pending definitive action by the Board.

Sec. 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec. 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec. 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec. 9. Membership Classifications. Members defined in this section, except Affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

This section rep sents an attempt clearly define the me bership categories a relate them to o another with regard voting and oth rights, and dues.

A. Regular. Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. Special. Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) Part-time practice. Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B. (5), may upon application, recommendation by the county medical society, and approval by this Society, be placed in this special category.

Some membersh classifications ha been eliminated; so renamed.

(2) Resident. Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) Temporary Military Service. Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) Associate. Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) Retired. Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) Life. Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years. They shall receive a certificate of Life Membership.

(7) Honorary. Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

C. Affiliate. Persons who are not otherwise eligible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

Because the Society's charter limits membership to licensed physicians, it was necessary to create a relationship for retired physicians (emeritus) who choose not to maintain an active license.

(1) Candidate. Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) Scientific Fellow. The Board may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

There is also created a "candidate" category for medical students and yet-to-be-licensed residents.

(3) Emeritus. Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec. 10. Dues and Assessments. Members shall pay dues and assessments as follows:

A. Regular members: full dues and assessments.

B. Physicians in part-time practice: one-half of regular member dues and assessments.

C. Physicians in residency or fellowship training: one-tenth of regular member dues and assessments.

Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

CHAPTER II
HOUSE OF DELEGATES

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society.

No substantive r visions as to comp sition and operati of the House of De gates. Some curre provisions are rel cated in this Chapter.

For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county society shall be entitled.

The secretary of each county society will send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec. 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec. 3. The speaker shall preside at the meetings of the House of Delegates.

Sec. 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec. 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec. 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Sec. 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec. 8. It shall receive for appropriate action the annual reports of the treasurer, secretary, and chairman of the Board of Directors.

Sec. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec. 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

CHAPTER III
ANNUAL ELECTION

Section 1. The House of Delegates, at its first session of the annual meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. This committee shall become operative at the close of the final session of that annual meeting and shall function until the close of the final session of the following year's annual meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the annual meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot from among the section delegates.

Minor editing only.

The Committee on Nominations shall convene at least two (2) months prior to the annual meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the positions to be filled.

Sec. 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the annual meeting.

Sec. 3. The House of Delegates shall elect the president-elect, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER IV
DUTIES OF OFFICERS

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

Restated and expanded.

a. Deliver an annual address to the House;
b. Serve as a member with right to vote on the Board;
c. Preside at meetings of the Executive Committee of the Board;
d. Participate, ex officio and without the right to vote, in sessions of the House;
e. Initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;

f. Support and articulate policies and programs adopted by the Board and the House;
g. Promote physician interest and active participation in the Society.

Sec. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

No change.

Sec. 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

Restatement of cu rent duties.

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;
c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.

Sec. 4. The secretary is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. Duties of the secretary shall include being secretary of and responsible to the Board; assisting the officers in making decisions and implementing actions; sharing convictions and arguing their merits as requested. Duties as chief executive officer shall be:

No change, but duties are *now* in c section.

a. Assume the general managerial duties of all Society divisions, activities, and personnel;
b. Be custodian of all records and papers belonging to the Society, except such as properly belong to the treasurer;
c. Keep account of and promptly turn over to the treasurer all funds of the Society which come into the secretary;
d. Maintain current copies of each component county society's constitution and bylaws;
e. Conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointments and duties;
f. With the approval of the Board, employ such assistants as are needed to effectively execute the policies of the Society;
g. Make an annual report to the House of Delegates.

CHAPTER V
BOARD OF DIRECTORS

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Minor editing, re- cation and renumb- ing, except for Sec 5 which is conside d to be an essential - vision to better - lineate and prot t the due process rig s of members.

Sec. 2. The Board shall meet during the annual meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec. 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the House of Delegates including all major actions and policy decisions of the preceding year.

Sec. 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include the expense of attending the annual meeting of the Society.

Sec. 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board.

The Board's right to original jurisdiction includes but is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions.

The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec. 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec. 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec. 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec. 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified.

When a district initially qualifies for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec. 11. The Board may elect as secretary one who need not be a physician or a member of the Society.

Sec. 12. The formation of salary schedules of all employees of the Society shall be the responsibility of the Board.

Sec. 13. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

CHAPTER VI
COMMISSIONS AND COMMITTEES

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers of the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office.

Minor editing only.

Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec. 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

CHAPTER VII
DUES AND ASSESSMENTS

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received.

October 15 chang to May 15.

Sec. 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of Delegates and to any other benefits and privileges of membership.

Current Sec. 3 d leted as ambiguous a difficult to administe

CHAPTER VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

Reference to specific principles; *i.e.*, AMA, removed to permit flexibility.

CHAPTER IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

Minor editing.

CHAPTER X
COUNTY SOCIETIES

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon application to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the secretary. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Updated to reflect current practices and delete extraneous material; some provisions relocated.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec. 4. Each component county society shall elect one or more delegates and an equal number of individual alternates, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec. 5. The secretary of each county society shall keep a roster of its members.

CHAPTER XI
SPECIALTY SECTIONS

Section 1. The House of Delegates shall establish specialty sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

Updated to reflect current practices.

Sec. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors. Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec. 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be reelected.

Sec. 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a ma-

jority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

Sec. 5. Each section shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec. 6. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

CHAPTER XII

Section 1. These Bylaws may be amended at any annual meeting by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

No change.

Sec. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed. ■

THE OPTOMETRIST REFERRAL LAW

In 1977 the Wisconsin Legislature enacted a law permitting optometrists in Wisconsin to use some topical drugs. The law, Chapter 280, Laws of 1977, includes a **mandatory** referral section—the first of its kind in this state. It is reprinted below since some physicians undoubtedly will be receiving referrals in the near future.

449.19 Referral to other medical specialists

If, during the course of examining a person, an optometrist determines the possibility of the existence of a pathological condition, the optometrist shall so advise the person and shall refer the person to an appropriate medical specialist for further evaluation.

WORKER'S COMPENSATION AND THE PHYSICIAN

Most Wisconsin physicians become involved with treatment of patients covered by Worker's Compensation, which provides payment of compensation for disability, and for medical expenses necessary because of injury or illness arising out of employment.

The State Medical Society's Committee on Environmental and Occupational Health, which maintains liaison with the Worker's Compensation Division, offers the following helpful information:

Filing reports. Filing reports is a direct responsibility of any physician who treats patients under the Worker's Compensation Program. WC-16 Medical Report on Industrial Injury is to be completed on a work-related injury or illness when the disability exceeds three weeks or when any permanent disability results therefrom. WC-16 is available from the insurance carrier or from WC Division. (The Committee on Occupational Health presently is involved in revising WC-16.) Information reported is used by the WC Division to determine the amount of compensation payable to the disabled worker.

Estimating disability. Learn to estimate disability according to standards set up by the WC Division. Other standards or schedules are fine for physicians' own information, but only the WC Division's standards are authoritative in Wisconsin (see "New Rules Established for Estimating Disabilities in Workmen's Compensation Cases" which appeared in the June 1975 Blue Book, pp 43-45).

Completing reports. Complete report forms carefully and fully. Learn terminology of the statutes concerning compensable employment disability.

Submitting reports. Submit reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. An unexpected misfortune may place the employe in urgent need of compensation.

Payment for reports. Occasionally physicians request reimbursement for preparing and filing reports. The Committee on Environmental and Occupational Health wishes to restate the following principles:

—Simplified reports including initial reports, progress reports, and final reports: No charge.
—WC-16 Report: No charge.
—When special reports are requested by the WC Division, or the insurance carrier requires an extensive or extra-ordinary report in lieu of a simplified report, a reasonable charge for preparation and filing is appropriate.

Don't be afraid to ask questions. Contact either the State Medical Society or Hugh Russell of the Worker's Compensation Division, 201 East Washington Ave, Box 7901, Madison, Wis 53707 (tel 608/266-1340).

"LIVING WILL" ON USE OF MEASURES TO SUSTAIN LIFE

Many people express their desire that no "heroic" measures be used to sustain their physical functions if this would result in their being totally incapacitated, comatose, or otherwise severely impaired. Various forms of a "living will", purporting to direct the scope of care to be given or withheld in such situations have been prepared and are in circulation.

It is unlikely that any of these documents can adequately address the complex medical judgments in a particular case but they do offer some guidance on the attitude of a patient who may no longer be able to speak for himself. It remains for serious and considered ethical and professional evaluation to see how and if the expressed attitude can be reflected in the management of the patient.

THE OATH OF HIPPOCRATES

I swear by Apollo, the physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgment, I will keep this oath and stipulation:

TO RECKON him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I WILL FOLLOW that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my art. I will not cut a person who is suffering from a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

WHATEVER, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this oath unviolated may it be granted to me to enjoy life and the practice of the art, respected by all men at all times but should I trespass and violate this oath, may the reverse be my lot.

FDA's toll-free number

The Food and Drug Administration has a toll-free number for physicians to call to report problems with drugs, medical devices, and *in vitro* diagnostic products. The purpose is to help the FDA determine when a product poses a significant potential health hazard. Problems with which the FDA is concerned are hazardous or potentially hazardous products, mislabeling, incomplete or confusing instructions, erroneous information, nonsterile products, packaging errors, and other quality control errors. The number to call is: **1-800-638-6725.**

DECLARATION OF GENEVA

Adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, September, 1948

AT THE TIME OF BEING ADMITTED AS MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

I WILL GIVE to my teachers the respect and gratitude which is their due.

I WILL PRACTICE my profession with conscience and dignity.

THE HEALTH OF MY PATIENT will be my first consideration.

I WILL RESPECT the secrets which are confided in me.

I WILL MAINTAIN by all means in my power, the honor and the noble traditions of the medical profession.

MY COLLEAGUES will be my brothers.

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I WILL MAINTAIN the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE THESE PROMISES solemnly, freely, and upon my honor.

PAST PRESIDENTS OF THE STATE MEDICAL SOCIETY OF WISCONSIN: 1953-1980

This is a partial listing. The complete listing from 1841 to 1972 appeared in the January 1973 issue.

H Kent Tenney, MD, Madison 1953-1954
Arthur J McCarey, MD, †Green Bay 1954-1955
Ervin L Bernhart, MD, Milwaukee 1955-1956
L Otis Simenstad, MD, †Osceola 1956-1957
Harry E Kasten, MD, †Beloit 1957-1958
Jerome W Fons, MD, †Milwaukee 1958
William B Hildebrand, MD, †Menasha 1959-1960
Edmund D Sorenson, MD, Elkhorn 1960-1961
Leif H Lokvam, MD, Kenosha 1961-1962
Nels A Hill, MD, Madison 1962-1963
William J Egan, MD, †Milwaukee 1963-1964
William P Curran, MD, Antigo 1964-1965
John H Houghton, MD, †Wisconsin Dells 1965-1966
Frank E Drew, MD, †Milwaukee 1966-1967
Harold J Kief, MD, Fond du Lac 1967-1968
William D James, MD, †Oconomowoc 1968-1969
Robert E Callan, MD, Milwaukee 1969-1970
Jerry W McRoberts, MD, Sheboygan 1970-1971
George A Behnke, MD, Kaukauna 1971-1972
Robert F Purtell, MD, Milwaukee 1972-1973
Gerald J Derus, MD, Madison 1973-1974
John E Dettmann, MD, Green Bay 1974-1975
Howard L Correll, MD, Arena 1975-1976
Charles J Picard, MD, Superior 1976-1977
Roy B Larsen, MD, Wausau 1977-1978
Jules D Levin, MD, Milwaukee 1978-1979
Darold A Treffert, MD, Fond du Lac 1979-1980

† Deceased

STATE MEDICAL SOCIETY OF WISCONSIN

Accreditation Program

for Continuing Medical Education

Information is available in printed form from either Bill Wendle, Scientific Affairs Coordinator, or Arlene K Meyer, Administrative Assistant in Continuing Medical Education, Health Services Division, State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; or telephone toll-free in Wisconsin 1-800-362-9080 (Madison area: 257-6781).

☆ ☆ ☆

On July 25, 1979 at the direction of its House of Delegates, the American Medical Association withdrew from the Liaison Committee on Continuing Medical Education (LCCME) and resumed the AMA's previous responsibility for accreditation of institutions and organizations offering continuing medical education programs. The AMA also recognized state medical associations as accrediting bodies for intrastate providers of continuing medical education.

The State Medical Society of Wisconsin's accreditation program functions under the authority of the AMA's newly created Committee on Accreditation of Continuing Medical Education (CACME). Twenty-four representatives from state medical societies, national medical specialty societies, AMA Section on Medical Schools and Resident Physician's Section, National Medical Association, American Hospital Association, Association for Hospital Medical Education, Federation of State Medical Boards, and medical specialty boards were appointed by the AMA Board of Trustees to CACME.

CATEGORY 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions).

CATEGORY 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

CATEGORY 3—Medical teaching.

CATEGORY 4—Papers, publications, books, presentations, and exhibits.

CATEGORY 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

CATEGORY 6—Other meritorious learning experiences.

continued on opposite page

Recipients of awards presented by the State Medical Society of Wisconsin — 1980

COUNCIL AWARD

Charles J Picard, MD, Superior

PRESIDENTIAL CITATION AWARD

John J Czajka, MD (Guadalupe Children's Medical and Dental Clinic, Milwaukee)

DISTINGUISHED SERVICE AWARD

Richard H Wasserburger, MD, Madison (posthumously)

HOUGHTON MEDICAL STUDENT AWARD

Jose Luna (Medical College of Wisconsin)
Lori Neumann (University of Wisconsin Medical School)

ELVEHJEM MEMORIAL LECTURE AWARD

Leonard B Seeff, MD, Washington, DC

BEAUMONT MEMORIAL LECTURE AWARD

George E Block, MD, Chicago, Ill

FIFTY YEAR CLUB AWARDS

See May 1980 issue of *Wisconsin Medical Journal*

A complete listing of recipients of awards for the previous years can be found in June 1979 issue of WMJ.

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CME Accreditation Program/continued

WISCONSIN INSTITUTIONS AND ORGANIZATIONS ACCREDITED *by SMSW and LCCME for continuing medical education programing at May 1, 1980*

Appleton Memorial & St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Deaconess Hospital, Milwaukee
Ft Atkinson Memorial Hospital, Ft Atkinson
Gundersen Medical Foundation Ltd & La Crosse Lutheran Hospital, La Crosse
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Lutheran Hospital, Milwaukee
Madison General Hospital, Madison
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital of Oconomowoc, Oconomowoc
Methodist Hospital, Madison
Mount Sinai Medical Center, Milwaukee
Osseo Area Municipal Hospital, Osseo
Sacred Heart Hospital, Eau Claire
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial & St Nicholas Hospitals, Sheboygan
St Agnes Hospital, Fond du Lac
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Hospital, La Crosse
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Mary's Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Rhinelander
St Michael Hospital, Milwaukee
St Vincent Hospital, Green Bay
Theda Clark Memorial Hospital, Neenah
Trinity Memorial Hospital, Cudahy
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Medical Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

Cancer Committee, St Francis Hospital, Milwaukee
American Cancer Society, Wisconsin Affiliate
American Heart Association, Wisconsin Affiliate
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
The Racine Academy of Medicine
State Medical Society's Section on Ophthalmology
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Clinical Cancer Center
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Otolaryngological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Obstetrics & Gynecology
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

Marinette-Florence County Medical Society

AMA Accredited

Dept CME, Medical College of Wisconsin
Dept CME, UW Center for Health Sciences
Interstate Postgraduate Medical Association
The State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists

THE WISCONSIN UNIFORM INSURANCE CLAIM FORM

—Is the only claim form approved by EDS Federal for Wisconsin medical claims submitted by physicians.

—Is accepted by major insurance carriers for all claims except CHAMPUS.

—Costs one third less than its national competitor.

—Is available in either 2-part snap-out or 2-part continuous sets.

It is available direct from SMS Services, Inc—just fill in the order form below and your order will be on its way to you within 48 hours of receipt.

---------- (CUT HERE) ----------

ORDER BLANK UNIFORM CLAIM FORMS

UCF3-799

RETURN ORDER FORMS TO:

SMS Services, Inc
330 East Lakeside Street
PO Box 1109
Madison, WI 53701

TYPE OF FORM DESIRED

SNAP OUT ☐
2-part (original & carbon) packed 1,500 per carton

CONTINUOUS, MARGINAL PINFEED ☐
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CHECK MUST BE ENCLOSED WITH ORDER
Payable to SMS Services, Inc.

FORMS TO BE SENT TO: (Print or Type)

Name _____

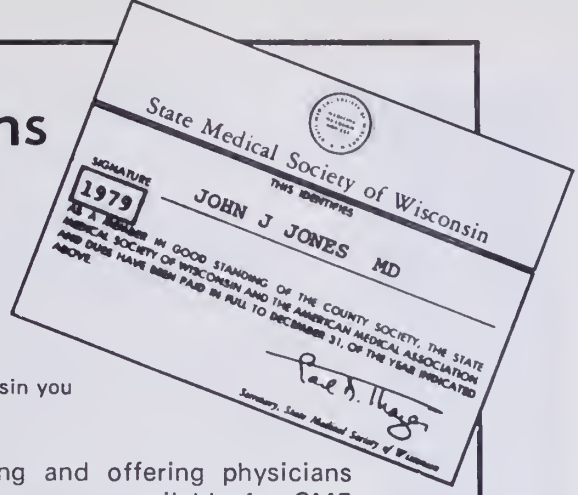
_____

Street _____

City _____ State _____ Zip _____

CIRCLE QUANTITY	Forms Price	UPS	Sales Tax	TOTAL
1,500	$ 33.75	$ 3.22	$ 1.48	$ 38.45
3,000	67.50	6.44	2.96	76.90
4,500	101.25	9.66	4.44	115.35
6,000	133.80	12.88	5.87	152.55
7,500	167.25	16.10	7.33	190.68
9,000	200.70	19.32	8.80	228.82
10,500	234.15	22.54	10.27	266.96
12,000	265.20	25.76	11.64	302.60

Why 4,835 physicians carry this card! . . . . .



These are challenging times for any profession —times when you need the active, aggressive support of your national, state, and county medical societies to give you the professional edge you need to advance and grow. As a member of the State Medical Society of Wisconsin you receive many valuable benefits. Among them:

- **SMS Annual Meeting**—Sponsored each spring and offering physicians quality scientific and socio-economic programs, many available for CME credit.
- **Wisconsin Medical Journal and Medigram**—These publications bring you the latest in medical news affecting you and your patients.
- **Wisconsin Physicians Planning Network**—Is working to assure physician representation in the health planning process and new health services systems.
- **An Organized Lobbying Effort**—Working in Madison to ensure Wisconsin physicians have a voice in healthcare problems and issues presented to the Wisconsin Legislature.
- **An Aggressive Socioeconomic Program**—The Physicians Alliance Division deals with the Medicare/Medicaid programs of government, monitors and comments on activities of third-party carriers of health insurance, and conducts efforts to inform the public of the costs and constraints of the healthcare delivery system.
- **Mediation and Peer Review**—Physicians, through a special commission, are "policing the profession" by mediating complaints of the public against physicians and where necessary imposing discipline.
- **Impaired Physician Program**—Was recently formed to help the impaired physician—the doctor suffering in some degree from alcoholism, other drug dependency, or mental illness.
- **Member Benefit Plans**—The Society offers comprehensive life, health and liability insurance plans for physicians and their families at attractive group rates. In addition, physicians can receive practice management tips at seminars sponsored by the Society and take advantage of car rental and travel programs at special low, "member" rates.
- **Grassroots Political Action**—Developed through the SMS Physicians Alliance, local physicians meet with their legislative representatives on a regular basis to discuss issues of importance to medicine.
- **Community Health**—Society physicians are working with community organizations and individuals in providing consumer health education programs to promote a healthier Wisconsin citizenry.
- **CESF**—The Society's Charitable, Educational and Scientific Foundation, through its physician members, administers a student loan program to help students prepare for careers in healthcare; sponsors postgraduate teaching programs for physicians; owns and operates the Museum of Medical Progress in Prairie du Chien; and for the past two years, has participated in a Jail Health Care Accreditation Program of the American Medical Association.
- **Uniform Claim Form**—These forms, developed by the Society working with local insurance carriers, can be used by physicians in submitting claims to all private insurance companies in Wisconsin, Medicare, and Medicaid.

Life is short . . . Art is long . . . Experience is difficult

Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was created in 1955 to perm members and other friends to present gifts or grants to projects vitally affecting medicir and public health. Its initial fund was used for student loans, but the Foundation's scop of interest has grown with the increased volume of financial contributions to worthy project

STUDENT LOANS. Since its inception, the Student Loan Program has helped students pr pare for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Fun for those loans have been given to the Foundation to administer according to the wish of the donors.

CHARITABLE ASSISTANCE. Through the Foundation there is an opportunity for profession persons to assist their colleagues in need. Personal hardship strikes at physicians and the families as well as others.

MEDICAL STUDENT EXTERNSHIP PROGRAM. This is a newer Foundation project which has be highly successful. It provides an eight-week externship with a family physician for studer who have completed their freshman year of medical school. Participating students receive f lowship grants from the Foundation.

RESEARCH ACTIVITY. Research projects on a variety of topics have been done with Found tion support. The Foundation is available to assist in planning, administering, and fundi investigations of a scientific or medical socio-economic nature.

CONTINUING MEDICAL EDUCATION. Educational activity, in the form of postgraduate teac ing programs, is a major thrust of the Foundation. Among these programs are a Speak Service to county medical societies, regional "in-depth" programs, and special conferences a lectures on such subjects as medical aspects of mental retardation, prematurity, the ne born, stroke, and athletic injuries as well as many other medical subjects.

Since 1975, the accreditation of continuing medical education programming of Wisconsin h pital and specialty groups has been implemented through the Foundation.

OPPORTUNITIES FOR GIVING. Gifts to the Foundation may take a number of forms: cash, l insurance, securities, land, books, instruments, stamp and coin collections, works of art, a other artifacts. Gifts may be unrestricted, restricted, or earmarked for specific purposes of terest to the donor.

In addition, service can be provided to those who wish to establish a Living Trust by nami the Foundation as trustee. Use of this mechanism can result in an immediate tax advant for the donor while providing a guaranteed income for life. The principal would rev to the Foundation upon death of the donor.

ALL TYPES OF CONTRIBUTIONS TO THIS FOUNDATION ARE TAX-DEDUCTIBLE.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE AESCULAPIAN SOCIETY of the State Medical Society's CES Foundation is seeking more members for support of its projects in this interesting and rewarding field. Recently two other Foundation groups involved in medical history were combined with the Aesculapian Society—the Permanent Commission to the Museum of Medical Progress and the Academy of Medical History—to make a stronger organization. The Society is now charged with the promotion and operation of the Museum of Medical Progress at Prairie du Chien as well as the preservation of Wisconsin's medical history. Although medical families comprise a large percentage of the membership, anyone who is interested in the group's objectives is eligible to belong. A newsletter is published quarterly to keep the membership aware of ongoing activities and a general membership meeting is held annually at the time of the Annual Meeting of the State Medical Society.

The Aesculapian Society has more than 900 members; it welcomes many more. The annual donation is $10 for regular or $25 for supporting membership. Make your check payable to the CES Foundation—Aesculapian Society, and mail to Box 1109, Madison, Wis 53701.

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Council and Officers of the State Medical Society and up to ten elected non-medical persons. In addition each of the 54 component county societies may elect a representative who is considered a corporate member of the Board. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected trustees constitute the Executive Committee of the Board. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

OFFICERS

PRESIDENT: R T Cooney MD, Portage—1980

VICE-PRESIDENT: Vacancy

TREASURER: L C Pomainville MD, Wisconsin Rapids—1980

SECRETARY: Mr E R Thayer, Madison—1980

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Vacancy (Brown)—1983
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filton Finn MD (Douglas)—1983
E Wahl MD (Eau Claire-Dunn-Pepin)—1982
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L Steidinger MD (Grant)—1983
acancy (Green)—1983
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Vacancy (Lafayette)—1983
Vacancy (Lafayette)—1980
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R W Edwards MD (Richland)—1983
J J Tordoff MD (Rock)—1983
William Bauer MD (Rusk)—1982
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Vacancy (Sawyer)—1982
J J Albright MD (Shawano)—1983
R M Senty MD (Sheboygan)—1982
C F Meyer MD (Trempealeau-Jackson-Buffalo)—1981
R A Starr MD (Vernon)—1981
Vacancy (Walworth) 1982
R G Edwards MD (Washington)—1982
W D James MD (Waukesha)—1981
J H Steiner MD (Waupaca)—1981
George W Arndt, MD (Winnebago)—1983
L C Pomainville MD (Wood)—1981

COUNCILOR DISTRICTS AND COUNCILORS

District	Councilor
1	John P Mullooly, MD, Milwaukee
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	Carl S L Eisenberg, MD, Milwaukee
	Elizabeth A Steffen, MD, Racine
	Wayne J Boulanger, MD, Milwaukee
	John J Foley, MD, Menomonee Falls
	William A Nielsen, MD, West Bend
	Irwin J Bruhn, MD, Walworth
	Thomas A Hofbauer, MD, Menomonee Falls
2	J D Kabler, MD, Madison
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6	Roger L von Helmburg, MD, Green Bay
	Irvin L Schroeder, MD, Plymouth
7	Paul S Haskins, MD, River Falls
8	Joseph M Jauquet, MD, Ashland

THE SOCIETY'S PLACEMENT SERVICE AIDS PHYSICIANS AND COMMUNITIES

One of the many functions of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians. This activity is called Placement Service.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to all physicians who contact Placement Service indicating that they desire to locate in Wisconsin or desire to relocate within the state. A list of physicians is sent to all communities who request assistance in obtaining a physician. The physicians contact the communities and the communities may contact the physicians. Physicians desiring associates may also request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years; even medical students have requested location lists. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Physicians and communities may also utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal*. This is a classified advertising section which is available to members of the State Medical Society, other physicians, communities, clinics, hospitals and others at reasonable rates.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, tel. 608/257-6781; and/or *Wisconsin Medical Journal*, Box 1109, Madison, Wis. 53701

Officers and Councilors 1980-1981

State Medical Society of Wisconsin

330 East Lakeside St (PO Box 1109), Madison, Wis 53701 • Tel 608/257-6781

Toll-free in Wisconsin: 1-800-362-9080

FICERS OF THE SOCIETY

ESIDENT (1980-1981)
Russell F Lewis, MD, 1000 N Oak Ave, Marshfield 54449

ESIDENT-ELECT (1980-1981)
Albert J Motzel Jr, MD, 1111 Delafield St, Waukesha 53186

CRETARY/GENERAL MANAGER
Earl R Thayer, 330 East Lakeside St, Madison 53701

EASURER (1980-1981)
Richard W Edwards, MD, 1313 W Seminary St, Richland Center 53581

EAKER (1979-1981)
**Duane W Taebel, MD,* 1836 South Ave, LaCrosse 54601

E-SPEAKER (1980-1981)
Chesley P Erwin, MD, 8700 West Wisconsin Ave, Milwaukee 53226

ST PRESIDENT (1980-1981)
Darold A Treffert, MD, 459 E First St, Fond du Lac 54935

'Elected in 1980 to complete unexpired tn of Doctor Motzel.

E COUNCIL

AIRMAN
Darold A Treffert, MD, 459 E First St, Fond du Lac 54935

E-CHAIRMAN
Timothy T Flaherty, MD, Neenah

OUNCILORS (by districts§)

RST: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha Counties

Jn P Mullooly, MD (1979-1982)
3430 W Capitol Dr, Milwaukee 53222

Al G LaBissoniere, MD (1979-1982)
0425 W North St, Wauwatosa 53226

Wne J Boulanger, MD (1978-1981)
2015 E Newport, Milwaukee 53211

**Thomas A Hofbauer, MD* (1978-1981)
PO Box 427, Menomonee Falls 53051

Jn J Foley, MD (1978-1981)
PO Box 427, Menomonee Falls 53051

Vliam A Nielsen, MD (1978-1981)
217 S 17th Ave, West Bend 53095

Jin J Bruhn, MD (1978-1981)
Walworth 53184

*Elected in 1980 to complete unexpired tn of Doctor Schmidt.

Carl S L Eisenberg, MD (1980-1983)
3003 West Good Hope Rd
Milwaukee 53209

Elizabeth A Steffen, MD (1978-1981)
734 Lake Ave, Racine 53403

SECOND: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, Sauk Counties

J D Kabler, MD (1979-1982)
1552 University Ave, Madison 53706

Cyril M Hetsko, MD (1979-1982)
1313 Fish Hatchery Rd, Madison 53715

Gerald C Kempthorne, MD (1979-1982)
PO Box 466, Spring Green 53588

William P Crowley, MD (1978-1981)
20 S Park St, Madison 53715

Allen O Tuftee, MD (1979-1982)
1905 Huebbe Parkway, Beloit 53511

THIRD: Buffalo, Crawford, Jackson, Juneau, LaCrosse, Monroe, Trempealeau, Vernon Counties

Pauline Jackson, MD (1980-1983)
1836 South Ave, LaCrosse 54601

FOURTH: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood Counties

John J Kief, MD (1980-1983)
1020 Kabel Ave, Rhinelander 54501

Jung K Park, MD (1980-1982*)
410 Dewey St, Wisconsin Rapids 54494

FIFTH: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

John U Peters, MD (1979-1982)
505 E Division, Fond du Lac 54935

Timothy T Flaherty, MD (1980-1983)
547 E Wisconsin Ave, Neenah 54956

SIXTH: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan Counties

Roger L von Heimburg, MD (1980-1983)
900 S Webster, Green Bay 54301

Irvin L Schroeder, MD (1979-1982)
210 Selma St, Plymouth 53073

SEVENTH: Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, Washburn Counties

Paul S Haskins, MD (1980-1983)
409 Spruce St, River Falls 54022

EIGHTH: Ashland, Bayfield, Douglas, Iron, Sawyer Counties

Joseph M Jauquet, MD (1978-1981)
200 7th Ave West, Ashland 54806

Past President *Treffert*
President *Lewis*
Speaker *Taebel*
President-elect *Motzel*
Vice-speaker *Erwin*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

CALENDAR YEARS 1979-1980; 1981-1982

Delore Williams, MD, 8501 W Lincoln Ave, West Allis 53227

Patricia J Stuff, MD, PO Box 522, Bonduel 54107

John K Scott, MD, 1605 Monroe St, Madison 53711

CALENDAR YEARS 1980-1981

Gerald J Derus, MD, 5001 Monona Dr, Madison 53716

Henry F Twelmeyer, MD, 2500 N Mayfair Rd, Wauwatosa 53226

ALTERNATE DELEGATES TO THE AMA

CALENDAR YEARS 1979-1980; 1981-1982

John D Riesch, MD, PO Box 427, Menomonee Falls 53051

Cornelius A Natoli, MD, 2760 Hagen Rd, LaCrosse 54601

Richard W Edwards, MD, 1313 W Seminary St, Richland Center 53581

CALENDAR YEARS 1980-1981

Warren H Williamson, MD, 500 Walton, Racine 53402

John R McKenzie Jr, MD, 415 S Meadow, Oshkosh 54901 ■

Map indicating location of districts, opite page.

Iote: Officers, councilors, delegates, and nbers of Commissions and Committees a elected at the Annual Meeting (March 1 0). Dates in parentheses indicate beginng and expiration of term of office.

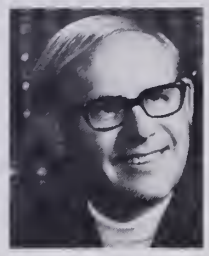
*Elected for a two-year term because the fourth district wished not to have both councilors' terms expiring in the same year.

AMA Delegates and Alternates' terms of office are on a calendar basis, although elected at the Annual Meeting.

Officers and Councilors: 1980-1981

STATE MEDICAL SOCIETY OF WISCONSIN

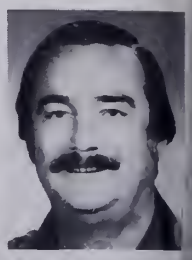
R F Lewis, MD
President



D A Treffert, MD
Past President
Council Chairman

A J Motzel, Jr, MD
President-elect

D W Taebel, MD
Speaker



R W Edwards, MD
Treasurer

E R Thayer
Secretary

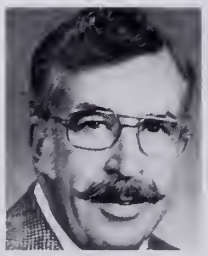
C P Erwin, MD
Vice-Speaker

T T Flaherty, MD
Council V-Chairman
Councilor, Dist 5

W J Boulanger, MD
Councilor, Dist 1

I J Bruhn, MD
Councilor, Dist 1

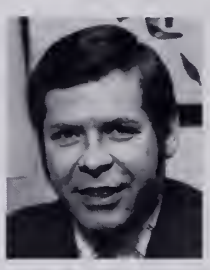
J J Foley, MD
Councilor, Dist 1



P J LaBissoniere, MD
Councilor, Dist 1

J P Mullooly, MD
Councilor, Dist 1

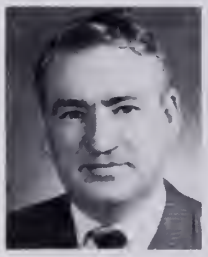
W A Nielsen, MD
Councilor, Dist 1



T A Hofbauer, MD
Councilor, Dist 1

C S L Eisenberg, MD
Councilor, Dist 1

E A Steffen, MD
Councilor, Dist 1

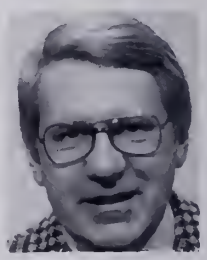


W P Crowley, MD
Councilor, Dist 2

A O Tuftee, MD
Councilor, Dist 2

C M Hetsko, MD
Councilor Dist 2

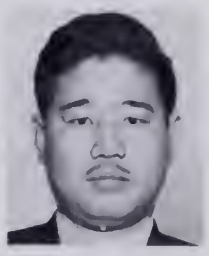
J D Kabler, MD
Councilor, Dist 2



G C Kempthorne, MD
Councilor, Dist 2

P M Jackson, MD
Councilor, Dist 3

J J Kief, MD
Councilor, Dist 4

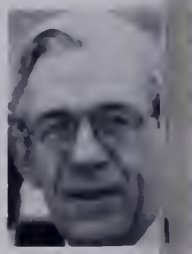


J K Park, MD
Councilor, Dist 4

J U Peters, MD
Councilor, Dist 5

R L von Helmburg, MD
Councilor, Dist 6

I L Schroeder, MD
Councilor, Dist 6



J M Jauquet, MD
Councilor, Dist 8

Commissions and Committees—1980-1981

State Medical Society of Wisconsin

330 East Lakeside St (Box 1109), Madison Wis 53701 • Tel 608/257-6781

Toll-free in Wisconsin: 1-800-362-9080

OMMISSIONS

CMMISSION ON PUBLIC IFORMATION

his commission shall be concerned about t members of this Society and their image w the public. It shall plan and execute p grams of effective public information and h lth education, assist component societies ir he conduct of similar programs, develop e ctive media relations, and recruit and r in physician members of the Society and e burage their active participation in the a irs of the county and state societies and th American Medical Association.

Rhard W Shropshire, MD, Madison, 1981

Vllace MacMullen, MD, Green Bay, 1981

Rhard A Henry, MD, Chippewa Falls, 981

Hbert F Sandmire, MD, Green Bay, 1982 *hairman*

C rles Sorensen, MD, Wisconsin Rapids, 982

S Graiewski, MD, Oshkosh, 1982

Jeph W Edgett, Jr, MD, LaCrosse, 1983

Mk J Popp, MD, Brookfield, 1983 *ice-chairman*

Vliam J Maurer, MD, Marshfield, 1983

WSCONSIN MEDICAL JOURNAL

he *Wisconsin Medical Journal* shall be th official journal of the Society. An ed- it al board consisting of the medical editor as chairman and six additional members sh l be responsible for all scientific, edi- tcl, and business affairs of the Journal. A editorial director, serving as chairman of a oup of no less than five editorial associ- at shall be responsible for regularly pro- vng items of editorial opinion for publica- ti in the editorial pages of the Journal.

EtORIAL BOARD

Vlor S Falk, MD, Edgerton, 1982 *hairman and Medical Editor*

Rhard D Sautter, MD, Marshfield, 1981

M F Lindert, MD, Milwaukee, 1981

Wne J Boulanger, MD, Milwaukee, 1982

Hold H Scudamore, MD, Monroe, 1982

Mvin F Huth, MD, Baraboo, 1983

Dn M Connors, Madison, MD, 1983

Grett A Cooper, MD, Madison, Emeritus

EtORIAL ASSOCIATES (appointed annually / Council)

Wne J Boulanger, MD, Milwaukee *hairman and Editorial Director*

Jn P Mullooly, MD, Milwaukee

T McDonell, MD, Waukesha

Rmond A McCormick, MD, Green Bay

Bnton H Field, Jr, MD, Milwaukee

---

hairman and vice-chairman of commis- sis and committees are elected at the first mting following the Annual Meeting. The B E BOOK is prepared prior to most of th e elections; therefore, some commissions a committees will not include these d gnations.

COMMISSION ON MEDIATION AND PEER REVIEW

This commission may have up to 25 members. It shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, professional ethics, and fees. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, fees, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Council. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the impaired physician program.

Gerald C Kempthorne, MD, Spring Green, 1981 *Chairman*

G John Weir, Jr, MD, Marshfield, 1981

John B McAndrew, MD, Oshkosh, 1981

Lloyd R Cotts, MD, Rice Lake, 1981

John Flannery, Jr, MD, Wausau, 1981

Joseph B Grace, MD, Green Bay, 1981

James M Huffer, MD, Madison, 1981

Thomas Jennings, MD, West Allis, 1981

John D Riesch, MD, Menomonee Falls, 1981

Michael McCormick, MD, Waukesha, 1982

Ronald J Darling, MD, Waukesha, 1982

Richard W Edwards, MD, Richland Center, 1982

Leo Grinney, MD, Racine, 1982

Charles Mann, MD, Madison, 1982

John A DeGiovanni, MD, Prairie du Sac, 1982

Charles E Koepp, MD, Marinette, 1983

Herman J Dick, MD, Sheboygan, 1983

Harry F Weisberg, MD, Milwaukee, 1983

Robert E Johnston, MD, Green Bay, 1983 *Vice-chairman*

Richard Logan, MD, Madison, 1983

Melvin F Huth, MD, Baraboo, 1983

Mark Lochner, MD, Waupaca, 1983

David Westgard, MD, LaCrosse, 1983

COMMISSION ON CONTINUING MEDICAL EDUCATION

This commission shall consist of nine appointed members and the deans of the two medical schools in Wisconsin, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commissions on Peer Review and Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two commissions; and the scientific program of the annual meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

John L Raschbacher, MD, Waukesha, 1981

Leonard H Wurman, MD, Wausau, 1981 *Vice-chairman*

James T Houlihan, MD, Woodruff, 1981

Edwin L Overholt, MD, LaCrosse, 1982

Bradley G Garber, MD, Osseo, 1982

Paul B McAvoy, MD, Neenah, 1982

Martin Z Fruchtman, MD, Waukesha, 1983

John J Koch, MD, Prairie du Sac, 1983

George A Berglund, MD, Milwaukee, 1983 *Chairman*

COMMISSION ON GOVERNMENTAL AFFAIRS

This commission shall concern itself with all state and federal health legislation, its analysis and communication to the membership; preparing and securing state or federal health legislation for the best interests of the public, scientific medicine, and the medical profession; legislative representation and liaison, state and federal; informing the membership of the Society of important proposed legislation and encouraging members to be active individually in political affairs; liaison between the Society and executive and legislative branches of government; coordination of county legislative committees required by the Bylaws.

Membership of the Commission on Governmental Affairs shall include a representative from each of the specialty sections of the Society. These representatives shall be appointed by the specialty sections annually. Such appointments shall be subject to the approval by the Council. Representatives on the Commission from the specialty sections need not be counted for purposes of a quorum for a meeting of the Commission on Governmental Affairs, but shall have the right to vote.

Joseph M Lubitz, MD, Oconomowoc, 1981 *Chairman*

Martin L Janssen, MD, Friendship, 1981

Gerald A Gehl, MD, Neenah, 1981

Thomas P Belson, MD, Waukesha, 1982

Theodore C Fox, MD, Antigo, 1982

J D Kabler, MD, Madison, 1982 *Vice-chairman*

Robert F Purtell, Jr, MD, Milwaukee, 1983

Jack D Edson, MD, Eau Claire, 1983

Raymond C Zastrow, MD, Wauwatosa, 1983

The Commission also has a voting representative from each of the specialty sections of the Society, and several subcommittees appointed by the Commission chairman.

PHYSICIANS ALLIANCE COMMISSION

This commission shall have 18 members consisting of one for each Councilor District, except that District 2 shall have two members and District 1 shall have seven members. In addition, the President of the State Medical Society, the Chairman of the Council, and Chairman of the Commission on Governmental Affairs will be ex officio members with vote. Nominations for membership on the commission shall be made by the Council Nominating Committee, but nominees shall be actively solicited from within each district by contact with the county medical societies and the medical staffs of hospitals. The commission shall be concerned with planning, organizing, and implementing appropriate programs to protect, promote, and achieve the socio-economic interests of the members of the State Medical Society of Wisconsin. It shall report to the Council at every regular meeting and annually to the House of Delegates, both as to its operations and policy recommendations.

Russell Quirk, MD, Racine, 1981
Robert Jackson, MD, Madison, 1981
Joseph C Diraimondo, MD, Manitowoc, 1981
Thomas Dehn, MD, Milwaukee, 1981
Richard Stone, MD, Milwaukee, 1981
Kenneth M Viste, MD, Oshkosh, 1982
Chairman
Matthew Meyer, MD, Waukesha, 1982
John Simenstad, MD, Osceola, 1982
Harry H Larson, MD, Ashland, 1982
John E Thompson, MD, Nekoosa, 1982
LaVern H Herman, MD, Waukesha, 1983
William L Treacy, MD, Milwaukee, 1983
Charles E Pechous, Jr, MD, Kenosha, 1983
Jordon Frank, MD, Beloit, 1983
Vice-chairman
Jack Lockhart, MD, LaCrosse, 1983

Ex officio voting members:
President, State Medical Society
Chairman of the Council
Chairman, Commission on Governmental Affairs

COMMISSION ON HEALTH PLANNING

This commission shall be concerned about planning for health care, including facilities and services and their organization to assure availability, access and quality of care; standards, guidelines and regulations affecting health care; distribution of medical services; relationships with allied health personnel; and matters pertaining to the Joint Commission on Accreditation of Hospitals.

John D Hart, MD, Shawano, 1981
Guenther Pohlmann, MD, Milwaukee, 1981
D Joseph Freeman, MD, Wausau, 1981
Edward J Lennon, MD, Milwaukee, 1982
Bruce J Stoehr, MD, Green Bay, 1982
Kermit L Newcomer, MD, LaCrosse, 1982
Marvin G Parker, MD, Racine, 1983
John Renner, MD, Madison, 1983
Frederic L Hildebrand, MD, Neenah, 1983

This commission also includes representatives of specialty sections/societies and chairmen of Physician HSA Task Forces with voting rights when present, provided they are SMS members, such appointments subject to approval by the Council.

COMMITTEES

COMMITTEE ON AGING AND EXTENDED CARE FACILITIES

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care.

Nicholas L Owen, MD, Milwaukee, 1981
Chairman
W E Rosenkranz, MD, Mukwonago, 1981
Vacancy, 1981
Elston L Belknap, Jr, MD, Madison, 1982
Edward Perry, MD, LaCrosse, 1982
Leslie H Stone, MD, Oshkosh, 1982
Joseph Springberg, MD, Beloit, 1983
Frederick W Blancke, MD, Madison, 1983
Vice-chairman
Gertrude Howe, MD, Fish Creek, 1983

COMMITTEE ON ALCOHOLISM AND OTHER DRUG ABUSE

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Ronald L Harms, MD, Shawano, 1981
Warren H Williamson, MD, Racine, 1981
Fred H Koenecke, MD, Madison, 1981
Roland Herrington, MD, Milwaukee, 1982
Marwood E Wegner, MD, St Croix Falls, 1982
Alan E Reed Jr, MD, Wauwatosa, 1982
Darold A Treffert, MD, Winnebago, 1983
Michael C Gordon, MD, Janesville, 1983
Dennis G Biros, MD, LaCrosse, 1983

COMMITTEE ON ENVIRONMENTAL AND OCCUPATIONAL HEALTH

This committee shall consist of 15 members and shall be concerned with the health and safety of persons in relation to their environment, including matters relating to occupational and rural health.

Wendelin W Schaefer, MD, Sheboygan
Melvin Blumenthal, MD, Monroe
Larry A Lindesmith, MD, LaCrosse
Robert W Page, MD, Marshfield
John T Schmitz, MD, Milwaukee
Frank A Walker, MD, Brookfield
Carl Zenz, MD, West Allis
Donald M Rowe, MD, Kohler
Edward P Horvath Jr, MD, Marshfield
Vernon Dodson, MD, Madison
Donald Welter, MD, Milwaukee
John J Beck, MD, Sturgeon Bay
Boyd Groth, MD, Mosinee
George H Handy, MD, Madison
Timothy A Correll, MD, Dodgeville
Mrs W W (Jame) Schaefer, Sheboygan, Auxiliary

Terms of the 15 MD members to be established by lot at the first meeting of the new, combined committee.

HOUSE OF DELEGATES
List appears in February issue page 67

COMMITTEE ON MATERNAL AND CHILD HEALTH

This committee shall be concerned about all aspects of health in pregnancy, childbirth, and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Richard C Brown, MD, Eau Claire, 1981
Walter R Schwartz, MD, Wauwatosa, 1981
Chairman
Raymond E Burrill, MD, Marshfield, 1981
Kilian H Meyer, MD, Richland Center 1982
Edward Buerger, MD, Waukesha, 1982
Curtis R Weatherhogg, MD, Madison, 1982
Vice-chairman
James C Tankersley, MD, LaCrosse, 1983
John E Inman, MD, Monroe, 1983
Vacancy, 1983

COMMITTEE ON MEDICINE AND RELIGION

This committee shall be concerned abou the medical-spiritual values of health car and the development of closer relationship between physicians and clergy to perm discussion of common problems in the tot treatment and care of patients.

Richard W Shropshire, MD, Madison, 1981
Frank J Cerny, MD, Fond du Lac, 1981
William O Myers, MD, Marshfield, 1981
John O Simenstad, MD, Osceola, 1982
John S Harris, MD, Appleton, 1982
John P Mullooly, MD, Milwaukee, 1982
Maxwell Weingarten, MD, Milwaukee, 198
John K Scott, MD, Madison, 1983
E Basil Jackson, MD, Milwaukee, 1983

COMMITTEE ON MENTAL HEALTH

This committee shall be concerned wi all aspects of mental health as an equal pa of the patient's total well-being.

Charles W Landis, MD, Milwaukee, 1981
C E Moore, MD, Fond du Lac, 1981
Robert F Goerke, MD, Milwaukee, 1981
David P Donarski, MD, Green Bay, 1982
William H Heywood, MD, Marshfield, 198
Pauline Jackson, MD, LaCrosse, 1982
William Garitano, MD, Marshfield, 1982
Terry Hankey, MD, Waupaca, 1982
Warren Olson, MD, Madison, 1982
Francis M Forster, MD, Madison, 1983
Theodore J Nereim, MD, Mount Hor 1983
Edward Meyer, MD, Oshkosh, 1983

COMMITTEE ON SAFE TRANSPORTATION

This committee shall be concerned ab the health and safety of all who may be fected by the use of vehicles of transpo tion on land, water, or in the air.

James L Weygandt, MD, Sheboygan Fa 1981
Fred Bunkfeldt, Jr, MD, Milwaukee, 1981
Glenn C Hillery, MD, Lancaster, 1981
Eugene Eckstam, MD, Monroe, 1982
Ralph F Hudson, MD, Eau Claire, 1982
Walter F Smejkal, MD, Manitowoc, 1982
Clarence E Moore, MD, Fond du Lac, 19
James M Huffer, MD, Madison, 1983
Elmer E Johnson, MD, Madison, 1983

OMMITTEE ON SCHOOL HEALTH

This committee shall be concerned about otecting and improving the health of ose attending the public or private schools this state, including matters related to letics.

orge H Handy, MD, Madison, 1981
orace K Tenney, III, MD, Madison, 1981
lward Zupanc, MD, Monroe, 1981
nes C H Russell, MD, Ft Atkinson, 1982
rnell Donahue, MD, Hartford, 1982
ck Spear, MD, Richland Center, 1982
illiam T Brodhead, MD, Madison, 1983
ank Walker, MD, Brookfield, 1983
wrence K Siegel, MD, Waukesha, 1983

OMMITTEE ON FEDERAL GISLATION of the Commission Governmental Affairs

bert F Purtell, Jr, MD, Milwaukee
Chairman
bert Toohill, MD, Milwaukee
ymond Zastrow, MD, Hartland
rence Jordahl, MD, Milwaukee
vid Weber, MD, Fond du Lac
chael P Mehr, MD, Marshfield
rl Eisenberg, MD, Milwaukee
ul Johnson, MD, Racine

OFFICIO:
Joseph M Lubitz, MD, Oconomowoc
Mrs. Daniel Shea, DePere ■

COUNCIL COMMITTEES: 1980-81

Executive Committee of the Council

Russell F Lewis, MD, Marshfield
President of the Society
Chairman
Darold A Treffert, MD, Fond do Lac
Immediate Past President and
Chairman of the Council
Albert J Motzel, Jr, MD, Waukesha
President-elect of the Society
Darold A Treffert, MD, Fond du Lac
Speaker of the House of Delegates
Timothy T Flaherty, MD, Neenah
Vice Chairman of the Council
John J Foley, MD, Menomonee Falls
Chairman, Finance Committee

Finance Committee of the Council

John J Foley, MD, Menomonee Falls, 1981
Chairman
William A Nielsen, MD, West Bend, 1981
Joseph M Jauquet, MD, Ashland, 1981
Cyril M Hetsko, MD, Madison, 1982
Jung K Park, MD, Wisconsin Rapids, 1982
Irvin L Schroeder, MD, Plymouth, 1982
Wayne J Boulanger, MD, Milwaukee, 1983
Richard W Edwards, MD, Richland Center
Treasurer, ex officio

Auxiliary Advisory Committee

Mrs Glenn M Seager, Stoddard
President of the Auxiliary
Mrs Donald A Peterson, Madison
President-elect of the Auxiliary
Russell F Lewis, MD, Marshfield
President of the Society
Albert J Motzel, Jr, MD, Waukesha
President-elect of the Society
Darold A Treffert, MD, Winnebago
Immediate Past President and
Chairman of the Council
Timothy Flaherty, MD, Neenah
Vice Chairman of the Council
Mr Earl R Thayer, Madison
Secretary ■

House of Delegates Nominating Committee

State Medical Society of Wisconsin 1980-81

District	*Name*	*Address*
1	David N Goldstein, MD	2039 - 19th Avenue Kenosha 53140
1	John D Riesch, MD	P O Box 427 Menomonee Falls 53051
1	Kenneth M Smigielski, MD	3615 W Oklahoma Ave Milwaukee 53215
1	Jerome J Veranth, MD	5605 Washington Avenue Racine 53406
2	Sandra Osborn, MD	1912 Atwood Avenue Madison 53704
2	James J Tydrich, MD *Secretary*	1313 W Seminary Street Richland Center 53581
3	Vernon M Griffin, MD	Mauston Clinic Mauston 53948
4	Richard H Ulmer, MD	Marshfield Clinic Marshfield 54449
5	Kenneth M Viste, Jr, MD	100 Stoney Beach Road Oshkosh 54901
6	John E Kraus, MD	1510 Main Street Marinette 54143
7	Richard A Henry, MD	2661 County Trunk I Chippewa Falls 54729
8	Clarence M Scott, MD	318 - 21st Avenue, East Superior 54880
Specialty Sections	Joel E Taxman, MD *Chairman*	1622 W Wisconsin Avenue Milwaukee 53233

AFFILIATED ORGANIZATION BOARDS: 1980-81

SMS Realty Corporation *Trustees*

Eugene J Nordby, MD, Madison, 1981
President
Richard W Edwards, MD, Richland Center, 1982
Vice President
John J Foley, MD, Menomonee Falls, 1983
Treasurer

SMS Services, Inc *Directors*

William P Crowley, MD, Madison, 1983
President
John P Mullooly, MD, Milwaukee, 1981
Vice President
Richard W Edwards, MD, Richland Center, 1982
Treasurer
Earl R Thayer, Madison, 1981
Secretary
Antoine Barrette, MD, Peshtigo, 1981
Timothy T Flaherty, MD, Neenah, 1982
Joseph M Jauquet, MD, Ashland, 1982
Paul G LaBissoniere, MD, Milwaukee, 1983
Allen O Tuftee, MD, Beloit, 1983 ■

SMS AUXILIARY: 1980-81

ELECTED OFFICERS

President: Mrs Glenn M Seager, Route 1, Box 126, Carla Court, Stoddard 54648
President-elect: Mrs Donald A Peterson, 1101 Merrill Springs Road, Madison 53705
Vice President: Mrs Leonard Torkelson, 1380 Franklin Street, Baldwin 54002
Recording Secretary: Mrs Robert C Baldwin, 119 Concord Avenue, Watertown 53094
Treasurer: Mrs Charles Yale, 209 Farwell Drive, Madison 53704
Immediate Past President: Mrs Kenneth M Smigielski, 3351 West Poe Street, Milwaukee 53215

DIRECTORS

East Central: Mrs K Alan Stormo, 270 Sheboygan Street, Fond du Lac 54935
West Central: Mrs Kenneth W Halgrimson, 2909 South Lexington Boulevard, Eau Claire 54701
Northeast: Mrs Gerald Gehl, 210 Elm Street, Neenah 54956
Northwest: Mrs Charles Longstreth, Route 1, Box 163J, Maple Ridge Road, Ashland 54806
Southeast: Mrs A R Pequet, 15635 Kata Drive, Elm Grove 53122
Southwest: Mrs C A Natoli, 2760 Hagen Road, LaCrosse 54601

APPOINTED OFFICERS

Parliamentarian:
Historian: Mrs Joseph Tobin, 601 Rock Avenue, Eau Claire 54701

EXECUTIVE SECRETARY

Mrs LaVerne Bartel, 330 East Lakeside Street, Madison 53715 ■

County Medical Societies

Presidents, Secretaries and Meeting Schedules

County	*President*	*Secretary*	*Meetings*
Ashland—Bayfield—Iron	Howard N V Sandin, Suite 9, 2101 Beaser Ave, Ashland 54806	Paul Van Pernis, 2101 Beaser Ave, Suite 2, Ashland 54806	On-call
Barron—Washburn—Burnett	James A Rugowski, Rt 1, Box 146A Cumberland 54829	Donald E Riemer, PO Box 127, Cumberland 54829	Second Tuesday of month
Brown	Raymond A McCormick, PO Box 1221 Green Bay 54305 *Treasurer:* Frederick J Lamont, 123 N Military Ave, Green Bay 54303	James R Mattson, 501 S Military Ave, Green Bay 54301 *Executive Secretary:* Ms Bernice Mangless, 501 S Military Ave, Green Bay 54301	Second Thursday of month
Calumet	Arturo M Ylagan, 251 East Main St, Chilton 53014	James C Pinney, 507-C West Main St, Hilbert 54129	On-call
Chippewa	Frederick D Cook, 1315 Ridge Wood Dr, Chippewa Falls 54729	Romeo B Sangalang, Rt 5, Chippewa Falls 54729	First Tuesday of month
Clark	A Mitat Algan, 400 Mill St, Loyal 54446	Narasimhulu Neelagaru, 110 Park St, Neillsville 54456	On-call
Columbia—Marquette—Adams	Victor C Guzman Jr, 1512 New Pinery Rd, Portage 53901	Frederick H Bronson, RR 2, Fox Glen Rd, Portage 53901 *Executive Secretary:* Mrs Elayne Hanson, 912 Cass St, Portage 53901	On-call
Crawford	Thomas F Farrell, 323 S Beaumont Rd Prairie du Chien 53821	Michael S Garrity, 610 East Taylor St, Prairie du Chien 53821	On-call
Dane	Hubert V Moss Jr, 30 South Henry St, Madison 53703	R Marshall Colburn, 413 Bryce Canyon Circle, Madison 53705	First Tuesday of month
Dodge	Norman J Schroeder II, 1200 Center St, Beaver Dam 53916	James S Berry, 707 South University Ave, Beaver Dam 53916	Last Thursday of month
Door—Kewaunee	David E Papendick, 801 Fourth St, Algoma 54201	Ferrin C Holmes, 345 South 18th Ave, Sturgeon Bay 54235	Fourth Tuesday of month, Sept thru May
Douglas	William D Berg, 2430 Logan Ave, Superior 54880	Jon F Franco, 3600 Tower Ave, Superior 54880	First Wednesday of month
Eau Claire—Dunn—Pepin	Jack D Edson, PO Box 224, Eau Claire 54701	J Randall Dennison, 733 West Clairemont Ave, Eau Claire 54701	Fourth Monday of month
Fond du Lac	James H Rupple, 80 Sheboygan St, Fond du Lac 54935 *Treasurer:* Douglas R Fownes, 505 East Division St, Fond du Lac 54935	Kirk A Veit, 80 Sheboygan St, Fond du Lac 54935	Fourth Thursday of month
Forest	Enzo F Castaldo, Laona 54541	Burton S Rathert, 101 West Washington, Crandon 54520	On-call
Grant	C L Steidinger, 1370 North Water St, Platteville 53818	John J David, Cassville 53806	On-call
Green	Carlos A Jaramillo, PO Box 596, Monroe 53566	George W Kindschi, Rt 2, Box 10, East Forest, Monroe 53566	Third Monday of month, Feb, Apr, June, Aug & Nov
Green Lake—Waushara	Roy Hong, Rt 2, Wild Rose 54984	Pepito M Emlano, PO Box 314, Wild Rose 54984	On-call'
Iowa	Timothy A Correll, 109 West Fountain St, Dodgeville 53533	Harald P L Breier, 207 Main St, Montfort 53569	Second Tuesday of month, recess for summer
Jefferson	Filemon C Yao, Satinwood Lane, Whitewater 53190	David C Grout, 426 McMillen St, Fort Atkinson 53538	Third Thursday of month
Juneau	Clayton L Weston, 600 South Monroe New Lisbon 53950	Jack Strong, 143 Division, Mauston 53948	On-call

Continued next page

County	President	Secretary	Meetings
enosha	John N Richards, 6215 Tenth Ave, Kenosha 53140 *Executive Secretary:* Mr Mark J Gorman, 3916 67th St, Kenosha 53140	A James Bennett, 3734 7th Ave, Suite 22, Kenosha 53140	First Thursday of month
aCrosse	David E Goodnough, 1836 South Ave, LaCrosse 54601	Thomas P Lathrop, 1836 South Ave, LaCrosse 54601	Third Monday of month
afayette	No Members in County Society		
anglade	John E McKenna, PO Box 400, Antigo 54409		
incoln	Nunillo L Bugarin, 221 East Washington Ave, Tomahawk 54487	Omer K Sanan, 216 North 7th St, Tomahawk 54487	Fourth Tuesday of month, Sept thru May
lanitowoc	David D Pfaffenbach, 1119 Marshall St, PO Box 705, Manitowoc 54220	Edward J Barylak, 601 Reed Ave, PO Box 279, Manitowoc 54220	Last Tuesday of month
larathon	William C Miller, 808 Third St, Wausau 54401	Julio C Davila, 333 Pine Ridge Blvd, Wausau 54401	Last Monday of month
larinette—Florence	John M Bell, 2500 Hall Ave, Marinette 54143	Stephen H Hoyme, 801 Wells St, Marinette 54143	Third Wednesday of month
filwaukee	Walter J Woloschek, 2500 North 108th St, Milwaukee 53226 *Executive Vice-President:* Mr Michael McManus, 411 East Mason St, Milwaukee 53202	Lucille B Glicklich, 5220 North Lake Dr, Milwaukee 53217	Dec (Annual), Feb, June & Oct
lonroe	Gustave A Landmann, PO Box 729, Tomah 54660	Jack D Brown, 202 South K St, Sparta 54656	Second Monday of month
conto	John R Culver, 150 North Main St, Oconto Falls 54154	Clyde E Siefert, 164 North Main St, Oconto Falls 54154	Third Tuesday of month
neida—Vilas	George Nemec Jr, Rt 1, Box 171A Woodruff 54568	Paul H K Figge Jr, 1020 Kabel Ave, Rhinelander 54501	On-call
utagamie	Charles F Dungar, 506 East Longview Dr, Appleton 54911	James G Bergwall, 217 West Cedar, Hortonville 54944	Third Thursday of month
zaukee	Aykarethu O Mammen, 1971 Washington St, Grafton 53024	M Thomas Chemotti, N94 W6539 Fieldcrest, Cedarburg 53012	Fourth Thursday of month
ierce—St Croix	George M Pope, Rt 2, Box 33, River Falls 54022	David M Woeste, 409 Spruce St, River Falls 54022	Third Tuesday of month
olk	Marwood E Wegner, 208 Adams St, South, St Croix Falls 54024	William R Byrne, 127 Keller Ave, North Amery 54001	Third Thursday of month
ortage	Vacancy	Daniel L Brick, 2501 Main St, Stevens Point 54481	
rice—Taylor	James G Sargeant, 98 Sherry Ave, PO Box 450, Park Falls 54552	Walther W Meyer, 101 North Gibson Ave, Medford 54451	Quarterly
acine	John W Foreman, 4701 Park Ridge Dr, Racine 53402 *Executive Secretary:* Mr Gilbert J Berthelsen, PO Box 592, Racine 53401	William H Stone, 5625 Washington Ave, Racine 53406 *Treasurer:* Carroll M Martin, 407 13th St, Racine 53403	Third Thursday of month
ichland	Kilian H Meyer, 1313 West Seminary St, Richland Center 53581	L Maramon Pippin, 1313 West Seminary St, Richland Center 53581	First Thursday of month
ock	Philip R Sholl, 580 North Washington St, Janesville 53545	William N Brandt, PO Box 551, Janesville 53545	On-call
usk	Richard J Romeis, 906 College Ave, West, Ladysmith 54848	Howard T Chatterton, 906 College, West, Ladysmith 54848	Third Tuesday of month
auk	John A DeGiovanni, 55 Prairie Ave, Prairie du Sac 53578	Paul R Bishop, 55 Prairie Ave, Prairie du Sac 53578	Second Tuesday of month, Sept thru May
awyer	Lloyd M Baertsch, Rt 6, Box 700, Hayward 54843	Paul Strapon III, Rt 6, Box 700, Hayward 54843	

County	President	Secretary	Meetings
Shawano	Richard R Stoughton, 117 East Green Bay St, Shawano 54166	Alois J Sebesta, 126½ South Main St, PO Box 311, Shawano 54166	Fourth Monday of month
Sheboygan	Bernard S Marsho, 531 North Seventh St, Sheboygan 53081	Donald D Ohme, 1011 North Eighth St, Sheboygan 53081	Third Thursday of month
Trempealeau—Jackson—Buffalo	William E Wright, Lock Box 90, Mondovi 54755	James J Dickman II, 610 West Adams St, Black River Falls 54615	Fourth Tuesday of month
Vernon	Phillips T Bland, 100 Melby St, Westby 54667	DeVerne W Vig, 125 West Jefferson, Viroqua 54665	On-call
Walworth	Menandro Tavera Jr, Rt 4, Box 246, Lake Geneva 53147	Edsel G Doreza, Kenosha St, Walworth 53184	Third Thursday of month
Washington	William M Claybaugh, N75 W22423 Chestnut Hill Rd, Sussex 53089	James D Froelich, 322 South 10th Ave, West Bend 53095	Fourth Thursday of month, except July, Aug & Dec
Waukesha	Walter E Gager, 102 East Main St, Waukesha 53186 *Executive Secretary:* Mr Robert Herzog, 850 Elm Grove Rd, Elm Grove 53122	Michael McCormick, 102 East Main St, Waukesha 53186 *Treasurer:* Matthew A Meyer, 217 Wisconsin Ave, Waukesha 53186	First Wednesday of month
Waupaca	Generoso N Rodriguez, PO Box 98, New London 54961	Jerry R Salan, 710 Riverside Dr, PO Box 387, Waupaca 54981	Second or Third Thursday of month
Winnebago	Safouh A Atassi, 169 E North Water St, Neenah 54956	Roy E Buck, 111 E North Water St, Neenah 54956	First Thursday of month, except July & Aug
Wood	Charles F Wood, 1221 48th St, South, Wisconsin Rapids 54494	Richard A Leer, 1000 North Oak Ave, Marshfield 54449	On-call

OFFICERS OF SPECIALTY SECTIONS* OF THE STATE MEDICAL SOCIETY as of record June 1, 1980

SECTION ON: ALLERGY AND CLINICAL IMMUNOLOGY

Chairman .....
Secretary-Treas ..... Martin Fruchtman, MD, 217 Wisconsin Ave, Waukesha 53186
Delegate ..... John J Ouellette, MD, 1 S Park St, Madison 53715
Alternate ..... Vacancy

ANESTHESIOLOGY

Chairman ..... Marshall R Jennison, MD, 2545 Maple Hill Lane, Brookfield 53005
Secretary-Treas .....
Delegate ..... James T Small Jr, MD, 904 Tenny Ave, Waukesha 53186
Alternate ..... Warren J Holtey, MD, 1000 N Oak Ave, Marshfield 54449

DERMATOLOGY

Chairman ..... Robert Jordon, MD, VA Hospital, Wood 53193
Secretary-Treas .....
Delegate ..... Joel E Taxman, MD, 1622 West Wisconsin Ave, Milwaukee 53233
Alternate ..... Nyles Eskirtt, MD, 3508 East Maria Dr, Stevens Point 54481

*Appointments to these Sections are generally made by the Specialty Societies. In some instances the appointees are not members of the State Medical Society and thus cannot serve in an official capacity; these names have been omitted.

EMERGENCY MEDICINE

Chairman ..... Thomas A Reminga, MD, 2025 E N port Ave, Milwaukee 53211
Secretary-Treas ..... C Randolph Turner, MD, 7335 M Terr, Milwaukee 53213
Delegate ..... Thomas A Reminga, MD, 2025 E N port Ave, Milwaukee 53211
Alternate ..... George Behnke, MD, 1107 River Dr, Kaukauna 54130

FAMILY PHYSICIANS

Chairman ..... Robert F Purtell, MD, 3316 V Wisconsin Ave, Milwaukee 53208
Secretary-Treas ..... Charles Steidinger, MD, 1370 N Water, Platteville 53818
Delegate ..... Robert F Purtell Jr, MD, 3316 V Wisconsin Ave, Milwaukee 53208
Alternate ..... John O Grade, MD, 1050 Legion Elm Grove 53122

INTERNAL MEDICINE

Chairman ..... Michael J Mally, MD, 1004 E Sun St, Hartford 53027
Secretary-Treas ..... Joseph J Mazza, MD, 1000 N Oak Marshfield 54449
Delegate ..... Anthony P Ziebart, MD, 2400 S St, #206, West Allis 53227
Alternate ..... Michael J Mally, MD, 1004 E S ner St, Hartford 53027

EDICAL FACULTIES

Chairman ..... Vacancy
Secretary-Treas ..... Vacancy
Delegate ..... Mark J Ciccantelli, MD, 610 N 19th St, Milwaukee 53233
Alternate ..... Manucher J Javid, MD, 600 Highland Ave, Madison 53792

UROLOGY

Chairman ..... Francis M Forster, MD, 4020 County M, Middleton 53562
Secretary-Treas .....
Delegate ..... Michael McQuillen, MD, 8700 West Wisconsin Ave, Milwaukee 53226
Alternate ..... Robert T Schmidt Jr, MD, 923 Eliza St, Green Bay 54301

UROSURGERY

Chairman ..... Ralph L Suechting, MD, 240 First St, Neenah 54956
Secretary-Treas ..... George R Bartl, MD, 1111 Delafield St, Waukesha 53186
Delegate ..... Ralph L Suechting, MD, 240 First St, Neenah 54956
Alternate ..... John K Peden, MD, 20 South Park St, Madison 53715

STETRICS-GYNECOLOGY

Chairman ..... Joseph C Fralich, MD, 2405 Northwestern Ave, Racine 53404
Secretary-Treas ..... E Howard Theis, MD, 92 Division St, Fond du Lac 54935
Delegate ..... William E Martens, MD, 10425 W North Ave, #226, Wauwatosa 53226
Alternate ..... Vacancy

THALMOLOGY

Chairman ..... Philip Taugher, MD, 2400 S 90th St, West Allis 53227
Secretary-Treas ..... John Sella, MD, 6114 W Capitol Dr, Milwaukee 53216
Delegate .....
Alternate ..... Robert Sullivan, MD, 612 E Longview Dr, Appleton 54911

THOPEDICS

Chairman ..... Vacancy
Secretary-Treas ..... Vacancy
Delegate ..... Vacancy
Alternate ..... Vacancy

OLARYNGOLOGY

Chairman ..... Thomas H Burrows, MD, 626 E Longview Dr, Appleton 54911
Secretary-Treas ..... Charles N Ford, MD, 1836 South Ave, LaCrosse 54601
Delegate ..... Glenn Seager, MD, 1836 South Ave, LaCrosse 54601
Alternate ..... Thomas Grossman, MD, 11945 W Pioneer Rd, Mequon 53092

THOLOGY

Chairman ..... Roland C Brown, MD, 2200 W Kilbourn Ave, Milwaukee 53233
Secretary-Treas ..... Charles P Nichols, MD, 709 South 10th, LaCrosse 54601
Delegate ..... Edward A Burg Jr, MD, 2025 E Newport Ave, Milwaukee 53211
Alternate ..... Robert Carlovsky, MD, 222 Cottage Ave, Fond du Lac 54935

PEDIATRICS

Chairman ..... Curtis R Weatherhogg, MD, 20 South Park St, Madison 53715
Secretary-Treas ..... Vacancy
Delegate ..... Richard L Myers, MD, 1821 South Webster Ave, Green Bay 54301
Alternate ..... Willaim H Bartlett, MD, 213 Carillon Dr, Madison 53705

PHYSICAL MEDICINE AND REHABILITATION

Chairman ..... John L Melvin, MD, 9001 W Watertown Plank Rd. Milwaukee 53226
Secretary-Treas ..... William LaJoie, MD, S32 W27641 Daleview Dr, Waukesha 53186
Delegate ..... William LaJoie, MD, S32 W27641 Daleview Dr, Waukesha 53186
Alternate ..... Sridhar V Vasudevan, MD, 9001 W Watertown Plank Rd, Milwaukee 53226

PLASTIC SURGERY

Chairman ..... Vaughn Demergian, MD, 30 South Henry St, Madison 53703
Secretary-Treas ..... Alan L Pohl, MD, 10425 West North, Milwaukee 53226
Delegate .....
Alternate ..... Vacancy

PSYCHIATRY

Chairman ..... Vacancy
Secretary-Treas ..... Vacancy
Delegate ..... Vacancy
Alternate ..... Vacancy

PREVENTIVE MEDICINE

Chairman ..... Richard Biek, MD, Rt #4, Box 148J, Waupaca 54981
Secretary-Treas ..... Paul Robert Ebling, MD, 2500 Overlook Terr, Madison 53705
Delegate ..... Richard Biek, MD, Rt #4, Box 148J, Waupaca 54981
Alternate ..... Paul Robert Ebling, MD, 2500 Overlook Terr, Madison 53705

RADIOLOGY

Chairman .....
Secretary-Treas ..... Daniel J Price, MD, 2400 W Villard Ave, Milwaukee 53209
Delegate ..... Loren E Hart, MD, Box 3006, Green Bay 54303
Alternate ..... Bruce Kirkham, MD, 3737 Claymore Lane, Eau Claire 54701

RESIDENT PHYSICIANS

Chairperson ..... Diana L Kruse, MD, 2302 Chalet Gardens Rd, Apt 2, Madison 53711
Secretary-Editor ..... Vacancy
Delegate .....
Alternate ..... Diana L Kruse, MD, 2302 Chalet Gardens Rd, Apt 2, Madison 53711

SURGERY

Chairman ..... Charles E Yale, MD, 600 Highland Ave, Madison 53792
Secretary-Treas ..... Richard B Windsor, MD, 1011 N 8th St, Sheboygan 53081
Delegate ..... J David Lewis, MD, 279 S 17th Ave, West Bend 53095
Alternate ..... Louis C Bernhardt, MD, 501 Shearwater Rd, Madison 53714

UROLOGY

Chairman ..... Raul Waters, MD, 1313 Fish Hatchery Rd, Madison 53715

Secretary-Treas ..... Charles Troup, MD, 2021 South Webster Ave, Green Bay 54301

Delegate ..... Daniel Gute, MD, 6300 N Port Was ington Rd, Milwaukee 53217

Alternate ..... Stuart Fine, MD, 2040 W Wiscons Ave, Milwaukee 53233 ■

PRESIDENTS AND SECRETARIES, WISCONSIN SPECIALTY SOCIETIES as of record June 1, 1980

WISCONSIN ALLERGY SOCIETY

President—Morton M Soifer, MD (Sept 1980), 707 W Glencoe Pl, Milwaukee 53217

Secretary—Martin Fruchtman, MD (Sept 1980), 217 Wisconsin Ave, Waukesha 53186

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

President—Marshall R Jennison, MD (Sept 1980), 2545 Maple Hill Lane, Brookfield 53005

Secretary—W Stuart Sykes, MD (Sept 1980), 1005 Columbia Rd, Madison 53705

WISCONSIN DERMATOLOGICAL SOCIETY

President—Robert Jordon, MD (Aug 1980), VA Hospital, Wood 53193

Secretary—Eugene Monroe, MD (Aug 1980), 3003 W Good Hope Rd, Milwaukee 53209

WISCONSIN CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

President—Thomas A Reminga, MD (Mar 1980), 2025 E Newport Ave, Milwaukee 53211

Secretary—C Randolph Turner, MD (Mar 1980), 7335 Maple Terr, Milwaukee 53213

WISCONSIN ACADEMY OF FAMILY PHYSICIANS

President—Robert F Purtell Jr, MD (June 1980), 3316 W Wisconsin Ave, Milwaukee 53208

Secretary—Charles Steidinger, MD (June 1980), 1370 North Water, Platteville 53818

WISCONSIN SOCIETY OF INTERNAL MEDICINE

President—Michael J Mally, MD (Sept 1980), 1004 E Sumner St, Hartford 53027

Secretary—Joseph J Mazza, MD (Sept 1980), 1000 N Oak Ave, Marshfield 54449

WISCONSIN NEUROLOGICAL SOCIETY

President—Phiroze L Hansotia, MD (May 1981), 1000 N Oak Ave, Marshfield 54449

Secretary—Phillip Green, MD (May 1981), 1000 N Oak Ave, Marshfield 54449

WISCONSIN NEUROSURGICAL SOCIETY

President—William F Bingham, MD (Sept 1980), 1836 South Ave, LaCrosse 54601

Secretary—George R Bartl, MD (Sept 1980), 1111 Delafield St, Waukesha 53186

WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY

President—Joseph Fralich, MD (July 1980), 2405 Northwestern Ave, Racine 53404

Secretary—E Howard Theis, MD (July 1980), 92 E Division St, Fond du Lac 54935

WISCONSIN ORTHOPAEDIC SOCIETY

President—Hugh Hickey, MD (Mar/Nov 1980), 7545 N Port Was ington Rd, Milwaukee 53217

Secretary—Jack Spankus, MD (Mar/Nov 1980), 2040 W Wiscon Ave, Milwaukee 53233

WISCONSIN OTOLARYNGOLOGICAL SOCIETY

President—Thomas Burrows, MD (April 1981), 626 E Longvi Dr, Appleton 54911

Secretary—Charles N Ford, MD (April 1981), 1836 South A LaCrosse 54601

WISCONSIN SOCIETY OF PATHOLOGISTS

President—Roland C Brown, MD (Nov 1980), 2554 N 100th Wauwatosa 53226

Secretary—Charles P Nichols, MD (Nov 1980), 709 S 10th, I Crosse 54601

WISCONSIN CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

President—Kenneth O Johnson, MD (May 1981), 3003 West Gc Hope Rd, Milwaukee 53209

Secretary—Ordean L Torstenson, MD (May 1981), 1313 F Hatchery Rd, Madison 53715

WISCONSIN PSYCHIATRIC ASSOCIATION

President—Rudolf W Link, MD (Jan 1981), 5534 Medical Cir Madison 53711

Secretary—Pauline Jackson, MD (Jan 1981), 1836 South Ave, Crosse 54601

WISCONSIN SOCIETY OF PHYSICAL MEDICINE & REHABILITATION

President—Walter L Modaff, MD (Apr 1981), 2545 Lampligh Lane, Brookfield 53005

Secretary—William LaJoie, MD (Apr 1981), S32 W27641 Dalev Dr, Waukesha 53186

WISCONSIN SOCIETY OF PLASTIC SURGEONS

President—Vaughn Demergian, MD (Apr 1981), 30 S Henry Madison 53703

Secretary—Alan L Pohl, MD (Apr 1981), 10425 West North M waukee 53226

WISCONSIN SOCIETY FOR PREVENTIVE MEDICINE

President—Richard Biek, MD (Mar 1981), Rt. #4, Box 14, Waupaca 54981

Secretary—Paul Ebling, MD (Mar 1981), 2500 Overlook Tc Madison 53705

WISCONSIN SOCIETY OF RADIATION ONCOLOGISTS

President—Delores A Buchler, MD (Mar 1981), 600 Highland A Madison 53792

Secretary—James D Cox, MD (Mar 1981), 8700 W Wisconsin A Milwaukee 53226

ISCONSIN RADIOLOGICAL SOCIETY

esident—June D Unger, MD (Oct 1980), VA Hospital, Wood 53193

cretary—Daniel J Price, MD (Oct 1980), 2400 W Villard Ave, Milwaukee 53209

SCONSIN SURGICAL SOCIETY

esident—Charles E Yale, MD (May 1981), 600 Highland Ave, Madison 53792

Secretary—Richard B Windsor, MD (May 1981), 1011 N 8th St, Sheboygan 53081

WISCONSIN UROLOGICAL SOCIETY

President—Raul Waters, MD (Apr 1981), 1313 Fish Hatchery Rd, Madison 53715

Secretary—Charles W Troup, MD (Apr 1981), 2021 South Webster Ave, Green Bay 54301 ■

ALEXANDER CALDER
Lithographs

8 Plaisir du néophyte
Joys of the neophyte

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127 East Silver Spring Drive
Milwaukee, Wisconsin 53217
(Guenther Complex)

Tuesday-Saturday
10:30 a.m.-4:30 p.m.
414/963-2043

A Handy Guide to SMS Services

This guide is designed to help you get help when you need it — on the many subjects for which your State Medical Society is prepared to be of professional assistance.

Even if you are unsure whom to call for information, don't hesitate to call SMS Headquarters. You will find a staff person eager to help.

Whenever calling you may use the toll free number 1-800-362-9080. If that line is busy, and you are in a hurry, use the regular number, 1-608-257-6781. Within area 608, call 257-6781.

Come to where the information is — call SMS.

Earl R. Thayer
Secretary - General Manager

Remember This Number

1-800-362-9080
TOLL FREE

It's Your "Hotline" To Service

State Medical Society of Wisconsin

P.O. Box 1109
330 E. Lakeside Street
Madison, Wisconsin 53701

Toll Free: 1-800-362-9080
Regular: 1-608-257-6781

Subject	Staff Membe
A	
Accounting - General	Marcella Herfel / Dee Mille Lee Johnsc
Accredition for CME	Bill Wendle / Arlene Mey
Address Changes or Inquiries	County Societie A-M — Jim Lundberg; Milwaukee — Marcella Herf; N-V — Dee Miller; W-Z — Sue Greenheck
Administrative Rules	Neal Neuberge Mike Brozek / Don Lo
Administrative Services Division	Lee Johnsc
Aging and Extended Care Facilities	Neal Neuberger / Bill Wend
Alcoholism and Other Drug Abuse	Bernie Marone
Allied Health Personnel	Bill Wend
AMA — Delegates, Policies & Activities	Joan Py
Annual Meeting	Bill Wendle / Arlene Mey
Audio-Visual Services	Diane Upt
Auxiliary	LaVerne Bart
C	
Cancer	Bill Wenc
Capitol Week (Legislative Bulletin)	Mike Brozek / Don Lo
Certificate-of-Need	Neal Neuberg
Charitable, Educational & Scientific Foundation	LaVerne Bar
Communications	Diane Upt
Community Health Programs	Beth Jon
Complaints About Medical Care	John LaBissonie
Consent Forms	Bernie Maron
Consumer Relations	Beth Jon
Continuing Medical Education	Bill Wenc
Corporate Legal Counsel	Bernie Maron
Cost Containment Activities	Brian Jens
Council Affairs (Board of Directors)	Joan P
County Medical Society Affairs including Constitution and Bylaws	Bernie Marone Lee Johns
D	
Decertification	Neal Neuberg
Discipline of Physicians	John LaBissonie
Drugs	Bernie Maron
E	
Economic Information (CPI, etc.)	Brian Jens
Emergency Medical Services	Bill Wenc
Environmental Health	Don Lord / Beth Jon
Ethics	John LaBissoniere / Bernie Maron

Subject	Staff Member
ods and Nutrition	Beth Jones
neral Management of SMS	Earl Thayer / Bernie Maroney / Joan Pyre
vernmental Affairs	Mike Brozek / Don Lord
24 Hospital Code	Bill Wendle / Neal Neuberger
alth Careers	Diane Upton
alth Education	Beth Jones
alth Information	Diane Upton
alth Insurance	
—Third Party Carriers	
alth Maintenance Organizations HMOs)	Earl Thayer
alth Manpower	Neal Neuberger
alth Planning	Neal Neuberger
alth Services Division	Doug Nelson
alth Systems Agencies	Neal Neuberger
spital By-Laws	Bill Wendle / Bernie Maroney
spitals & Health Facilities	Bill Wendle / Neal Neuberger
spital-Physician Relations and Due Process	John LaBissoniere / Bernie Maroney
use of Delegates of SMS	Joan Pyre
paired Physicians	John LaBissoniere
urance and Membership Programs	Peter Wood / Lee Johnson
Auto Leasing Plan	
Avis Rental Plan	
Collection Service	
Disability Insurance	
Health Insurance	
Life Insurance	
Office Protection Plan	
Overhead Expense Insurance	
Retirement Plans	
Seminars	
Sponsored Tours	
erns and Residents	Brian Jensen
JI Health Care	Parks Reinhardt
(AH) Joint Commission on Accreditation of Hospitals	Bill Wendle
gal Information	Bernie Maroney
gislation and Regulations	
State	Mike Brozek / Don Lord
Federal	Rick Reas / Brian Jensen
ensure of Physicians and Others	Bernie Maroney
iling Label Requests	Marcella Herfel
ternal and Child Health	Bill Wendle / Arlene Meyer
dia Relations	Diane Upton
diation of Patient Complaints	John LaBissoniere
dicaid (T-19)	Brian Jensen/Rick Reas
dical Assistants	John LaBissoniere
dical Education	Bill Wendle

Subject	Staff Member
Medical History	LaVerne Bartel
Medical - Legal Issues	Bernie Maroney
Medical Museum, Prairie du Chien	LaVerne Bartel
Medical Records	Bernie Maroney
Medical Student Loans	
—Applications	LaVerne Bartel
—Repayments	Noreen Krueger
Medicare (T-18)	Brian Jensen
Medicine and Religion	LaVerne Bartel
Medigram	Diane Upton
Membership (Classifications, Dues, etc.)	County Societies A-M — Jim Lundberg Milwaukee — Marcella Herfel N-V — Dee Miller W-Z — Sue Greenheck
Membership Recruitment	Diane Upton / Brian Jensen
Mental Health	Neal Neuberger
N	
Negotiations	Brian Jensen
Newspapers - News Releases	Diane Upton
Nursing Homes	Neal Neuberger
O	
Occupational Health	Beth Jones
P	
Pamphlets on Health Care	Diane Upton
Patient Compensation Panels	Rick Reas
Peer Review	Doug Nelson / John LaBissoniere
Physicians Alliance Division	Brian Jensen
Physician Distribution	Neal Neuberger / Doug Nelson
Physician Information - Biographical	Sue Greenheck / Jim Lundberg
Physician Placement Service	Marge Stafford
Physician Recognition Award	Bill Wendle / Arlene Meyer
Political Action	Brian Jensen
Practice Management	Peter Wood / Lee Johnson
Professional Liability (Malpractice Insurance and Related Matters)	Rick Reas
PSRO	Doug Nelson
Public Health	Beth Jones
Public Relations	Diane Upton
R	
Radio	Diane Upton
Rental - AVIS Rental Car Discount	Peter Wood
Residents	Brian Jensen
Rural Health	Beth Jones
S	
Safe Transportation	Bernie Maroney
School Health	Beth Jones
Scientific Affairs	Bill Wendle
Speakers	
—Scientific	Bill Wendle / Arlene Meyer
—Other	Diane Upton
Specialty Society Services	Bill Wendle
Sports Medicine	Beth Jones
Student Loans and Scholarships	LaVerne Bartel

Subject	Staff Member

Summer Externship Program
—Coordination ..... John LaBissoniere
—Grant Payments ..... Dee Miller

T

Tax Problems..... Bernie Maroney / Peter Wood
Television ..... Diane Upton
Title 18 (Medicare) ..... Brian Jensen
Title 19 (Medicaid) ..... Brian Jensen/Rick Reas

U

Uniform Claim Form ..... Bill Guerten

W

WHCLIP (Wisconsin Health Care Liability Insurance Plan)
—Applications for Coverage..... Peter Wood
—General Information..... Rick Reas
Wisconsin Medical Journal ..... Mary Angell / Marge Stafford
Wisconsin Physicians Planning Network (WPPN)..... Neal Neuberger
Wisconsin Work Week of Health ..... LaVerne Bartel / Diane Upton
Women's Health Issues..... Beth Jones

SMS-Affiliated Organizations

Toll Free: 1-800-362-9080
Regular: 1-608-257-6781

Auxiliary of SMS ..... LaVerne Bartel
CES Foundation ..... LaVerne Bartel
SMS Realty Corporation..... Lee Johnson
SMS Services, Inc..... Lee Johnson / Peter Wood
WISPAC (Wisconsin Physicians Political Action Committee)..... Brian Jensen/Gina Brdenhagen

Specialty Services

Toll Free: 1-800-362-9080
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SMS Section on Ophthalmology (Legislative Services) ..... Mike Brozek
Wisconsin Academy of Physicians' Assistants..... Bill Wendle
Wisconsin Council of Child and Adolescent Psychiatry..... Bill Wendle
Wisconsin Psychiatric Association ..... Bill Wendle
Wisconsin Society of Oral Surgeons ..... Bill Wendle

County Society Services

Toll Free: 1-800-362-9080
Regular: 1-608-257-6781

Dane County Medical Society, Madison Office ..... John LaBissoniere
Medical Society of Milwaukee County
Mediation / Membership, Milwaukee Office ..... Mary Rodriguez—414-271-4328
Mediation, Madison Office ..... John LaBissoniere
Membership, Madison Office..... Marcella Herfel

SMS - Physicians Alliance Field Consultants By County

DISTRICT 1
Lois Riley
1-414-271-4328*
1-414-964-6524 (Home)
Milwaukee

DISTRICT 2
Ken Opin
1-608-257-6781*
1-608-255-2226 (Home)
Dane
Grant
Green
Iowa
Jefferson
Lafayette
Richland
Rock

DISTRICT 3
Calvin Dexter
1-414-498-3400*
1-414-842-8962 (Home #same)

Brown
Calumet
Dodge-Eastern Half
Door
Fond du Lac
Kewaunee
Manitowoc
Marinette-Southern Half
Oconto-Southeast
Outagamie
Sheboygan
Waupaca
Winnebago

DISTRICT 6
Tim Lynch
1-414-271-4328*
1-414-964-5780 (Home)
Kenosha
Milwaukee (part-time)
Ozaukee
Racine
Walworth
Washington
Waukesha

*Field Consultant
Answering Service

DISTRICT 4
Paul Jacobson
1-715-835-1753*
(Home # same)
Ashland
Barron
Bayfield
Buffalo
Burnett
Chippewa
Clark-Western Half
Crawford
Douglas
Dunn
Eau Claire
Iron
Jackson
La Crosse
Monroe
Pepin
Pierce
Polk
Price-Northern Half
Sawyer
St. Croix
Trempealeau
Vernon
Washburn

DISTRICT 5
Marv Stromer
1-715-845-8259*
1-608-868-2334 (Home)
Adams
Clark-Eastern Half
Columbia
Dodge-Far Western Half
Florence
Forest
Green Lake
Jefferson-Northwest Corn
Juneau
Langlade
Lincoln
Marathon
Marinette-Northern Half
Marquette
Oconto-Northwest
Oneida
Price-Southern Half
Portage
Rusk
Sauk
Shawano
Taylor
Vilas
Waushara
Wood

If you are unable to reach your field consultant, call Rick Reas, SMS Physicians Alliance—

Toll Free: 1-800-362-9080 or
Regular: 1-608-257-6781

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared or obtained at the direction of the Council and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Dept., State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.
- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.
- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.
- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Revised 1978—Single copy 25¢ with order.)
- **If You Have a Complaint About Medical Care**—Medical care is a personal matter between patient and physician. Yet, sometimes misunderstandings arise about what the physician hopes to accomplish and what the patient expects. This brochure, aimed at patients, explains the State Medical Society's grievance and peer review system.
- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $1.00 with order.)
- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abnormal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10" x 11½". For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $11.00; complete guide without binder: $10.00—to accompany order.)
- **Make Yours a Smokeless Pregnancy**—Points out the dangers of smoking during pregnancy and its effects on the fetus.
- **Guide to the Service Corporation Law**
- **Physician and Hospital Records: Retention and Inspection**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959.
- **Legal Responsibilities of the Physician-Patient Relationship.**
- **Report of the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force**—Recommendations in this report were adopted by the Governor's Health Planning and Policy Task Force, October 23, 1972.
- **A Scientific Test of the Chiropractic Theory**—The first experimental study of the basis of the theory demonstrates that it is erroneous. Written by Edmund S. Crelin and reprinted by permission of *American Scientist.*
- **Advertisements on Health Care Costs**—County Medical Societies may obtain upon request reproduction proofs on using health care costs for placement in their local newspapers.
- **Rubella—Red Measles Brochure**—This conveniently sized 2½" x 4" sized brochure alerts women to the necessity of being immunized for Rubella before they become pregnant. The brochure also reminds parents to have their children immunized for the red measles. Perfect for patient billing statements or waiting rooms.
- **To Your Good Health**—Explains the reasons behind rising health care costs and offers tips on how to save money on medical expenses.
- **Alcohol and Your Unborn Baby . . .** —Warns women of the harmful effects alcohol can have on an unborn child. Available in both English and Spanish versions.
- **To All My Patients, Partners in Good Health**—Explains the rights and responsibilities physicians and patients have in medical care. Available in standard brochure or smaller "statement stuffer" form.
- **I Want To Know What You Think**—a questionnaire physicians can use with patients to elicit their attitudes and opinions regarding his/her medical practice.
- **So You've Been Sued . . . Now What?**—a brochure prepared by the SMS Medical Liability Committee which answers 12 questions physicians commonly ask about medical malpractice lawsuits.

STATE GOVERNMENT AGENCIES

A VALUABLE REFERENCE FOR PRACTICING PHYSICIANS AND ALLIED HEALTH PERSONNEL

Department of Health and Social Services

1 W Wilson St, Madison, Wis 53702
Tel 608/266-3681

EXECUTIVE STAFF

SECRETARY
Donald Percy 266-3681

DEPUTY SECRETARY
Terry Willkom 266-3681

DIVISION ADMINISTRATORS

Peter Tropman 266-8402
Policy and Budget

Nate Harris 266-3173
Management Services

Elmer Cady 266-2471
Corrections

Bernard Stumbras 266-3416
Economic Assistance

Terry Willkom
(Acting Administrator) 266-1511
Health

Burton Wagner 266-2701
Community Services

Terry Willkom 266-1281
Vocational Rehabilitation

DIVISION OF HEALTH

1 W Wilson St; Room 280
PO Box 309
Madison, Wis 53701
Tel 608/266-1511

Note: Use box number on First Class Mail for all bureaus.

ACTING ADMINISTRATOR
Terry Willkom

DEPUTY ADMINISTRATOR
Vacant

OFFICE OF OPERATIONS AND MANAGEMENT
Vacant

BUREAUS

Planning **266-7295**
- Staffing of Health Policy Council and its committees
- Development of State Health Plan
- Liaison with Health Systems Agencies and review of their plans and budgets
- Coordination of categorical health planning process
- Review of categorical health plans
- Liaison with agencies (public and private) that implement the State Health Plan

Needs Review **266-7384**
- Service licensure
- Development of health facilities plan
- Review of categorical grants appeal
- Hospital rate review

Health Care Financing Control **266-2522**
- Administration of the Medical Assistance Program
- EPSDT—Early and periodic screening, diagnosis and treatment for children and other screening activities

Quality Compliance **266-8847**
- Title 18 and Title 19 certification
- Hospital and nursing home standard setting and enforcement
- Patient care evaluation
- Construction and plan review
- Development of facilities standards

Prevention **266-1251**
- Development and promotion of prevention programs
- Standard epidemiology
- Environmental epidemiology
- Immunization activities
- Communicable diseases
- Chronic diseases
- Participation in preventive efforts within and outside the Department of Health and Social Services
- Promotion of research into major causes of illness and death and sponsorship of demonstration projects designed to reduce and eliminate root causes
- Laboratory certification

Community Health **266-2661**
- Public health nursing
- Public health nutrition
- Dental health
- Maternal and child health
- Family planning

Institutional Health Services .266-57
- Assurance of sufficient levels of phys cal health care for all inmates in co rectional institutions and at Centr State Hospital
- Management of the provision of suc services to insure effectiveness and e ficiency
- Recruitment and staffing of heal care positions in the correctional ins tutions

Environmental Health .....**266-17(**
(1400 E Washington Ave, Madison 53702)
- Certification of Grade A milk
- Inspection of hotels, restaurants a food vending services where not pe formed by local public health agenci
- General environmental sanitation
- Recreational inspection
- Radiation protection
- Occupational health services
- Development of emergency medic services systems

Health Statistics **266-19**
- Vital Statistics
- Resource data
- Demographic and special analysis
- Services data

Drug Quality Review Board **266-7239**
Marie Roth, PhD, Chairman, Brookfield
Gerald Freitag, RPh, Greendale
Paul Bass, PhD, Madison
Kathleen Hickson, RPh, Superior
Harris Friedman, PhD, Milwaukee
William Janssen, MD, Mequon
Robert Schwartz, RPh, Madison

• • •

STAFF: Division of Health, Bureau of Planning, Room 523, One West Wilson St, Madison, Wis 53702 (phone 608/266-7295)

EGIONAL OFFICES

ivision of Health

o 1—MADISON 53719
5712 Odana Road
Tel 608/266-2245

o 2—MILWAUKEE 53216
6815 W Capitol Dr
Tel 414/466-9763

o 3—FOND DU LAC 54935
485 S Military Rd; PO Box 269
Tel 414/922-1290

o 4—GREEN BAY 54304
1298 Lombardi Ave
Tel 414/497-3219

o 5—LACROSSE 54601
District State Office Building, 104
3550 Mormon Coulee Rd
Tel 608/785-9431

o 6—EAU CLAIRE 54701
District State Office Building, 136
718 W Clairemont Ave
Tel 715/836-5362

o 7—WISCONSIN RAPIDS 54494
District State Office Building
1681 Second Ave S; PO Box 277
Tel 715/423-4730

o 7—RHINELANDER 54501
1831 N Stevens St; PO Box 1165
Tel 715/369-2840

DIVISION OF HEALTH
Regions

No 8—Information should be obtained from Eau Claire District

Note: Use box numbers on First Class Mail

IVISION OF COMMUNITY ERVICES

ate Office: 1 W Wilson St, adison, Wis 53702. l: 608/266-2701

dministrator 266-2701
Burton A Wagner

puty Administrator 266-9648
Paul R Keys

sistant Administrator for gional Operations 266-9879
John Erickson

sistant Administrator for ogram 266-2722
Jerry Foy

UREAUS

ling **266-2536**
Douglas Nelson, Director

ternate Care **266-3443**
Severa Austin, Director

velopmental Disabilities ..**267-7921**
Gerald Dymond, Director

cohol and Other Drug use **266-3442**
Larry Monson, Director

ntal Health **266-2719**
William Buzogany, Director

ildren, Youth and Families 266-5774
Robert Lizon, Director

fice of Coordinated Community rvices **266-9707**
William Griffin, Director

fice of Divisionwide rvices **266-9707**
Kary Hyre, Acting Director

Office of Regulation and Licensing **266-0468**
Barbara Voltz, Acting Director

REGIONAL OFFICES

WESTERN
Royal Roberts, Director
Box 228
718 West Clairemont Ave, Eau Claire 54701
Tel 715/836-2174

EASTERN
Lewis McCauley, Director
Box 3730
1181 Western Ave, Green Bay 54303
Tel 414/497-4226

SOUTHERN
Rex Duter, Director
3601 Memorial Drive, Madison 53704
Tel 608/249-0441

MILWAUKEE
Gerald Berge, Director
819 North 6th St, Milwaukee 53203
Tel 414/224-4501

SOUTHEASTERN
John Bauer, Director
225 Executive Dr, Brookfield 53005
Tel 414/257-4450

NORTHERN
Robert Heide, Director
Schiek Plaza, Box 697, Rhinelander 54501
Tel 715/362-7800

DISTRICT OFFICES

FOND DU LAC 54935
485 South Military Road
Box 1069
Tel 414/922-6810

ASHLAND 54806
601 2nd St, West, Box 72
Tel 715/682-3404

WISCONSIN RAPIDS 54494
1681 Second Ave, South
Box 636
Tel 715/423-4305

LaCROSSE 54601
3550 Mormon Coulee Road
Box 743
Tel 608/785-9453

Controlled Substances Board **266-7586**

Darold A Treffert, MD, Chairman, Fond du Lac Mental Health Center, Fond du Lac

June Dahl, PhD, Vice-chairman, Assistant Professor of Pharmacology, University of Wisconsin-Madison, Madison

Robert L Maile, Pharmacy Examining Board, Milwaukee

Gary Rohde, Secretary, Dept of Agriculture, Trade and Consumer Protection, Madison

Donald E Percy, Secretary, Dept of Health and Social Services, Madison

Bronson C La Follette, Attorney General, State of Wisconsin, Madison

* * *

STAFF: Division of Community Services, Bureau of Alcohol and Other Drug Abuse, Room 434, One West Wilson St, Madison, Wis 53702 (phone 608/266-7586)

DIVISION OF ECONOMIC ASSISTANCE

State Office: 18 S Thornton Ave
Box 8913, Madison, Wis 53708
Tel: 608/266-3416

Administrator 266-3035
Bernard Stumbras

Deputy Administrator 266-3039
Charles Holton

Office of Operations and Management 266-2445
William Lentz, Director

BUREAUS

Planning and Implementation 266-2850
Lowell Trewartha, Director

Program Compliance 266-1080
Mary Southwick, Director

Child Support 266-0528
Duane Campbell, Director

Social Security Disability Insurance 266-1981
Robert Cohen, Director

DIVISION OF VOCATIONAL REHABILITATION

State Office: 131 W Wilson St, 7th Fl
Madison, Wis 53702.
Tel: 608/266-1281

Administrator 266-2168
Patricia Kallsen

BUREAUS

Client Services 266-1283
John Biddick, Director

- Regional Administrators
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  Southeastern Region, *Ken Kassner* 266-1878
  Milwaukee Region, *Rod VanDeventer* 266-0605
  Eastern Region, *Bill Newberry* 266-0233
  Northern Region, *Don Snyder* 266-1950

Blind 266-0224
Rodney Kossick, Director

- Business Enterprise, *William Utz* 266-1116
- Workshop for Blind, *John Baumgart* 414/771-5311

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Olaf Brekke, Director

- Facilities Section, *Joseph Weiss* 266-6713
- Trust Fund/SSI, *Richard Kosmo* 266-3729
- Planning and Evaluation *Susan Kidder* 266-0930

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Patrick Mommaerts, Director

- Affirmative Action, *Cleo Eliason* 266-9248
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- Public Information, *Sharon Milliken* 266-3956
- Purchasing, *Wallis Roberts* ..266-8835
- Rules and Manuals, *Harry Emerson* 266-8636
- Staff Development, *Sue Kell* 266-2179

FIELD OFFICES

WESTERN REGION

L E Opheim, Supervisor
517 Walker Ave
PO Box 1228
Eau Claire 54701
Tel 715/836-4263

Michael Schroeder, Supervisor
219 West Knapp St
Rice Lake 54868
Tel 715/234-6806

John Purcell, Supervisor
333 Buchner Place
LaCrosse 54601
Tel 608/785-9500

SOUTHERN REGION

Joseph D'Costa, Supervisor
Highway 51, North
Northridge Shopping Center
Portage 53901
Tel 608/742-2150

Paul Rasmussen, Supervisor
1 South Park St
Madison 53715
Tel 608/266-3655

Wayne Olson, Supervisor
101 South Main St
Janesville 53545
Tel 608/755-2780

SOUTHEASTERN REGION

K F Krumnow, Supervisor
1570 East Moreland Blvd
Waukesha 53186
Tel 414/548-5850

Robert Barbee, Supervisor
5200 Washington Ave
Racine 53406
Tel 414/636-3388

Willie Riley, Supervisor
1115 56th St
Kenosha 53140
Tel 414/656-6453

MILWAUKEE REGION

Frank Broder, Supervisor
819 North 6th St
Milwaukee 53203
Tel 414/224-4677

Noreen Haupt, Supervisor
6815 West Capitol Dr
Milwaukee 53216
Tel 414/527-0250

Jeanne Leland, Supervisor
3555 South 27th St
Milwaukee 53221
Tel 414/643-1919

EASTERN REGION

Roger Siegworth, Supervisor
1181 Western Ave
PO Box 3627
Green Bay 54303
Tel 414/497-3417

James Mather, Supervisor
424 Washington Ave
Oshkosh 54901
Tel 414/424-2028

Paul Monzel, Supervisor
485 South Military Rd
PO Box 1438
Fond du Lac 54935
Tel 414/921-5883

George Herrmann, Supervisor
832 Niagara Ave
Sheboygan 53081
Tel 414/459-3883

NORTHERN REGION

R C Huser, Supervisor
130 South Stevens St
PO Box 894
Rhinelander 54501
Tel 715/369-3930

John Roemer, Supervisor
110 East Grand Ave
Wisconsin Rapids 54494
Tel 715/424-1100

C Carroll Tapp, Supervisor
400 East Thomas St
Wau au 54401
Tel 715/845-9261

L R Forslund, Supervisor
917 Tower Avenue
Superior 54880
Tel 715/392-8171 ■

)epartment
f Industry,
abor and
luman Relations

) 8ox 7946, 201 E Washington Ave,
adison, Wis 53707
1 608/266-7552

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seph N Noll, *Secretary* ..... *Madison*
nald L Semmann,
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Edwin Kehl, Acting Administrator
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prenticeship and Training 266-3331
Charles T Nye, Administrator
ministration 266-1024
Stephen J Reilly, Administrator
nployment and Training Services
William F Grenier ..... 266-5534 ■

)epartment
f Regulation
nd Licensing

1400 E Washington Ave,
Madison, Wis 53702
Tel 608/266-2112

n Jansen Haney, Secretary 266-8609
Adix, Deputy Secretary
lissa Kepner, Executive Assistant

JREAU OF HEALTH
ROFESSIONS

ve Exo, Director 266-0483

(rtial listing)

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Vice-chairman
lliam Baker, MD (1980), Monroe
Mary Reddin (1980), Milwaukee
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W Dudley Johnson, MD (1981), Milwaukee
Walter Washburn, MD (1982), Madison
Thomas Roskos, DO (1982), Hartland
George Daley, MD (1983), Milwaukee
Richard Eckberg, MD (1983), Stevens Point

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Deanna Zychowski, Madison 266-2811
Administrative Assistant

* * *

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Council on Physician's Assistants
Podiatry Examining Council

Denistry Examining Board

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STAFF
Lowell E Nass, Asst Attorney General
Mary J Moore, Administrative Assistant

* * *

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Pharmacy Examining Board

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Chairman
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Joan K Nuttall, RN (1983) ..... Neenah ■

HELPING THE RETARDED, DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be mentally retarded.

A resource the physician may wish to use in counseling the family is the local Association for Retarded Citizens. And a call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family in their county.

There should be local resources, psychological services, OT, etc available to complement the physician's examination. Also there are several clinics within the state that provide specialized evaluations for the persons who are mentally retarded and for persons with other developmental disabilities.

- CHILD DEVELOPMENT CENTER

  Dr June Dobbs, Director
  Child Development Center
  Milwaukee Children's Hospital
  1700 West Wisconsin Ave
  Milwaukee, Wisconsin
  (414) 931-4069

- UNIVERSITY HOSPITALS

  Dr Charles Schoenwetter
  H6 4th Floor, 600 Highland Ave
  Madison, Wisconsin 53792
  (608) 263-6421

- WAISMAN CENTER ON MENTAL RETARDATION

  Linne Cain, Intake Coordinator
  1500 Highland Ave
  Madison, Wisconsin 53706
  (608) 263-5777

- COMPREHENSIVE EVALUATION CLINIC FOR MULTIPLI-HANDICAPPED CHILDREN

  Ms Marilyn Gratto
  Miller-Dwan Hospital
  502 East 2nd Street
  Duluth, Minnesota 55805
  (218) 727-8762

Further information may be obtained from Rosemarie Reed, Information and Referral Outreach, Wisconsin Association for Retarded Citizens, Inc, 2700 Laura Lane, Middleton, Wis 53562; (608) 831-3444.

Health Policy Council

Chairman, HPC
Ben R Lawton, MD, Marshfield 54449
Tel 715/387-5275 or 387-1711

Secretary, HPC
Robert Durkin, Madison 53701
Tel 608/266-1511

Roger Baird, Menasha 54952
Tel 414/734-8960

Byford Baker, Milwaukee 53205
Tel 414/265-5167

William Blockstein, PhD, Madison 53706
Tel 608/262-3480

Rodney Bohn, Sturgeon Bay 54235
Tel 414/743-5510 or 743-3934

Henry Carrera, Merton 53056
Tel 414/538-1106

Myrvin Christopherson, PhD, Stevens Point 54481

Kenneth Clark, Milwaukee 53213
Tel 414/771-0700

John O Danielson, Superior 54880
Tel 715/392-8386 or 392-8101

Gary DeByl, DePere 54115
Tel 414/336-6739

Halsey Douglas, Menomonie 54751
Tel 715/235-4103

Dolores Ecker, Chilton 53014
Tel 414/439-1260

Ronald F Edwards, Woodruff 54568
Tel 715/356-2148

Belle Fiedler, Madison 53711
Tel 608/274-1818

Mary Hanrahan, Muscoda 53573
Tel 608/739-3320

Joseph M Jauquet, MD, Ashland 54806
Tel 715/682-4545

David R Jaye, Marshfield 54449
Tel 715/387-7111

Gwendolyn Jernstedt, Ashland 54806
Tel 715/682-6176

Charles Laible, Superior 54880
Tel 715/392-8281

Reverend Calvin Larson, Oshkosh 54901
Tel 414/235-4653

Barry Lloyd, Kenosha 53140
Tel 414/658-3821

Margaret Miller, Milwaukee 53233
Tel 414/271-8181

Joan Olson, Wisconsin Rapids 54494
Tel 715/423-8714

John Peters, MD, Fond du Lac 54935
Tel 414/922-3700

Marian Piper, Madison 53702
Tel 608/266-3034

John Prince, Eau Claire 54701
Tel 715/839-4367

Walter Rattan, MD, Kenosha 53140
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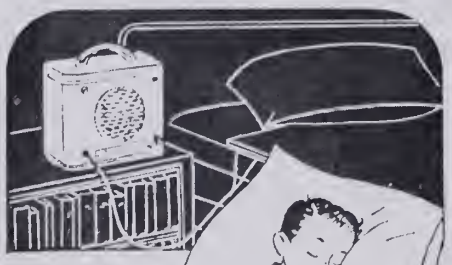

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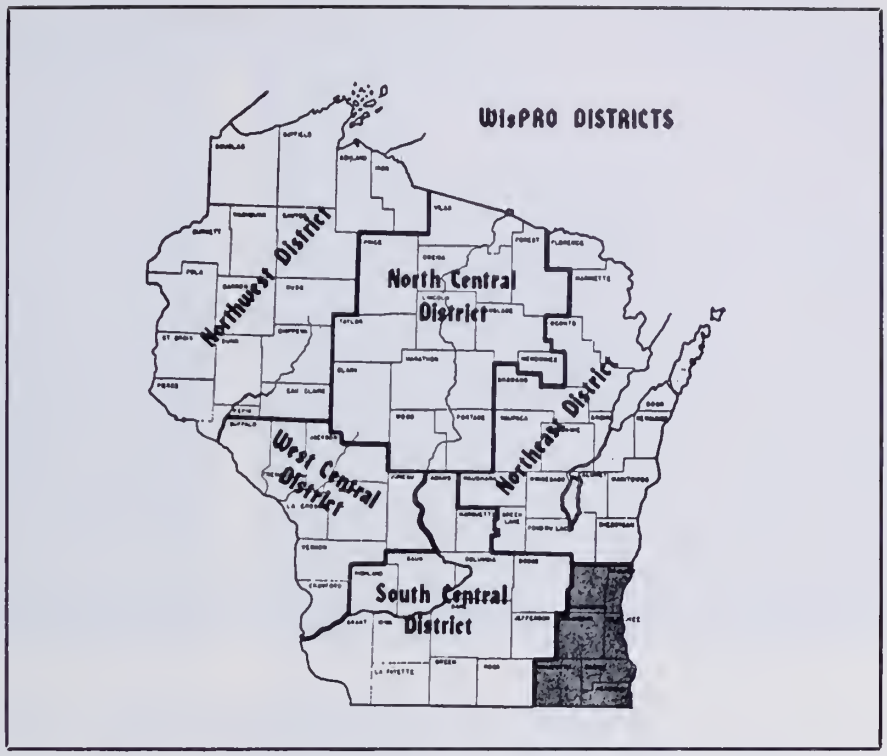

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Physicians are no longer automatically exempt from serving as a juror. However, there are some qualifying circumstances under which a physician might be excused in the discretion of a judge for hardship or extreme inconvenience. Physicians interested in further details may contact the SMS Physicians Alliance Division: toll-free 1-800-362-9080.

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Section 448.12 of the Wisconsin Statutes, quoted below, is concerned with legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 448.12 reads as follows:

"Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the sick without having a license or a certificate of registration, shall be liable to the penalties and liabilities for malpractice; and ignorance shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

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Organizational SMS

Physician distribution study continues

The SMS Council, at its May 17 meeting, approved 12 of 13 recommendations of a special report examining the supply and distribution of physicians. Continued study will be given a major recommendation calling for the use of state General Purpose Revenue (GPR) funds to finance a State Health Service Corps. The report from an ad hoc committee chaired by Kermit Newcomer, MD, LaCrosse, concludes that there is no numerical shortage of physicians in Wisconsin but that there are "physician deficiency areas" where more physicians are needed, particularly in primary care. Final report is due in July.

Other highlights of the May 17 Council meeting include:

Public Health —Reviewed a report on the public health system in Wisconsin prepared by an ad hoc committee of the Council chaired by Robert Carlovsky, MD, Fond du Lac. A Council committee was established to consider the Society's report in light of a report on public health recently completed by the State Dept of Health and Social Services, and prepare a final draft with recommendations for the July meeting of the Council.

Medical Discipline—Following review by the SMS Commission on Mediation and Peer Review, the Council suspended the membership of Dale V Moen, MD, Shell Lake, for one year pending correction of certain medical practice patterns.

In another case, on appeal, the Council confirmed the Commission's findings that a physician's "use of diagnostic tests was excessive." This physician was under review by HEW for Medicare services.

Alcohol and Drug Abuse—Approved a statement by the SMS Committee on Alcoholism and Other Drug Abuse in regard to "Prescribing Habits with Benzodiazepine Class of Drugs." This statement will appear in its entirety in the June BLUE BOOK issue of the *Wisconsin Medical Journal.*

Marijuana—Directed the SMS Commission on Public Information to disseminate information contained in a 1980 SMS House of Delegates resolution declaring marijuana to be a "dangerous drug."

Quality Assurance—Established an ad hoc committee to evaluate quality assurance and to propose legislation to support or encourage more effective programs in Wisconsin.

Environmental Health—Renamed the recently merged committees on environmental health the "Committee on Environmental and Occupational Health."

WHCLIP—Appointed Fred Kriss, MD, Madison, to serve as the Society's representative on the Board of Governors of the Wisconsin Health Care Liability Insurance Plan, starting July 1.

Indochina and Other Refugees—Authorized Council Chairman Darold Treffert, MD and SMS staff to meet with organizations involved in efforts to assimilate Indochina and other refugees in Wisconsin, especially in regard to meeting their healthcare needs.

Decertification—Directed Society staff to continue present discussions with DHSS regarding promulgation of decertification rules. If by the end of 1980 it appears that the program cannot be effectively implemented, SMS will introduce a bill seeking repeal of the decertification law.

Appointments—Appointed Dean M Connors, MD, Madison, to the Editorial Board of the *Wisconsin Medical Journal*; reelected Paul LaBissoniere, MD, Wauwatosa, William Crowley, MD, Madison and Allen Tuftee, MD, Beloit, to the SMS Services, Inc Board of Directors; reappointed Wayne Boulanger, MD, Milwaukee, to the Finance Committee of the Council, and named Duane Taebel, MD, LaCrosse, to the Council's Executive Committee.

Medical Reimbursement—Went on record as opposing efforts by HEW to implement a regulation on July 1, 1980 which would require that Medicare reimbursement be made to hospital-based physicians under Part B only if (a) the services require performance by a physician in person and, (b) they contribute to the diagnosis or treatment of a patient. All other services performed by a hospital-based physician would be reimbursed to the hospital on a reasonable cost basis. SMS will communicate its concerns regarding the HEW action to the American Medical Association and to Wisconsin members of Congress. ■

SMS annuity unit value: $2.92

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.92 as of April 30, 1980. This compares with $2.83 at March 31, 1980 and $3.13 at February 29, 1980. ■

H/D Nominating Committee sets September 28 meeting

The SMS House of Delegates Nominating Committee will meet on Sunday, September 28, at 10:00 am at Society headquarters in Madison, to receive nominations for the following positions for which a slate of candidates will be presented to the House of Delegates at the 1981 Annual Meeting, March 26-28:

President-elect for 1981-82

Speaker of the House of Delegates for 1981-83 (two-year term) to succeed Duane W Taebel, MD, LaCrosse, who was elected to the unexpired term as Speaker of Doctor Motzel, 1980-81

Vice Speaker of the House of Delegates for 1981-82 to succeed Chesley P Erwin, MD, Milwaukee (currently a one-year term, but the proposed revision of the Constitution and Bylaws to be acted upon in 1981 recommends a two-year term)

AMA delegates for calendar years 1982 and 1983 to succeed Gerald J Derus, MD, Madison and Henry F Twelmeyer, MD, Wauwatosa

AMA alternate delegates for calendar years 1982 and 1983 to succeed John R. McKenzie Jr, MD, Oshkosh and Warren H Williamson, MD, Racine

The Nominating Committee, chaired by Joel E Taxman, MD, Milwaukee, urges participation of the membership at large in the nomination process, and requests that nominations and curriculum vitae, and a statement of willingness to serve if elected, be mailed to the committee at the State Society office in advance of the September 28 meeting date. All candidates, with a member of the Society to nominate them, should be present at the meeting to present their views and answer any questions.

Members of the Nominating Committee appear elsewhere in this BLUE BOOK issue. ■

DHSS official discusses physician reimbursement with Alliance Commission

Bureau of Health Care Financing Director Martin Preizler was on hand at the April 18 SMS Physicians Alliance Commission meeting to map out how the bureau plans to comply with a legislative mandate to achieve greater uniformity in statewide physician reimbursement in the Medical Assistance (Title 19) Program.

Included in the recently passed Budget Review Bill was a provision directing the Dept of Health and Social Services to report to the Legislature's Joint Finance Committee by September 1980 with recommendations to eliminate "parity" problems between urban and rural physician reimbursement and to develop a simplified methodology for determining reimbursement.

Preizler said the Department is working on a four-phase approach to the problem which would take four to five years to implement. Step one is already underway says Preizler. By June 1 CPT-4 procedure and ICD9-CM diagnosis codes will be mandated for all Medicaid claims.

Secondly, DHSS is in the process of incorporating Medicaid charge data into the Medicaid profile data base. This will give DHSS a more accurate description of what physician's charges are in the Title 19 program. Currently Medicare data is used as the data base for Medicaid.

In regard to subsequent phases, Preizler had not decided what these would entail but did say a comparison of the prevailing rate (the 75th percentile charged by a physician for a given procedure in a given geographic region), Medicare charges and Medicaid payments would be done to see whether the number of geographic regions can be reduced.

Finally, he said DHSS would be researching ways to eliminate reimbursement differences between specialties. ■

CONTRIBUTIONS CES FOUNDATION APRIL 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for April 1980.

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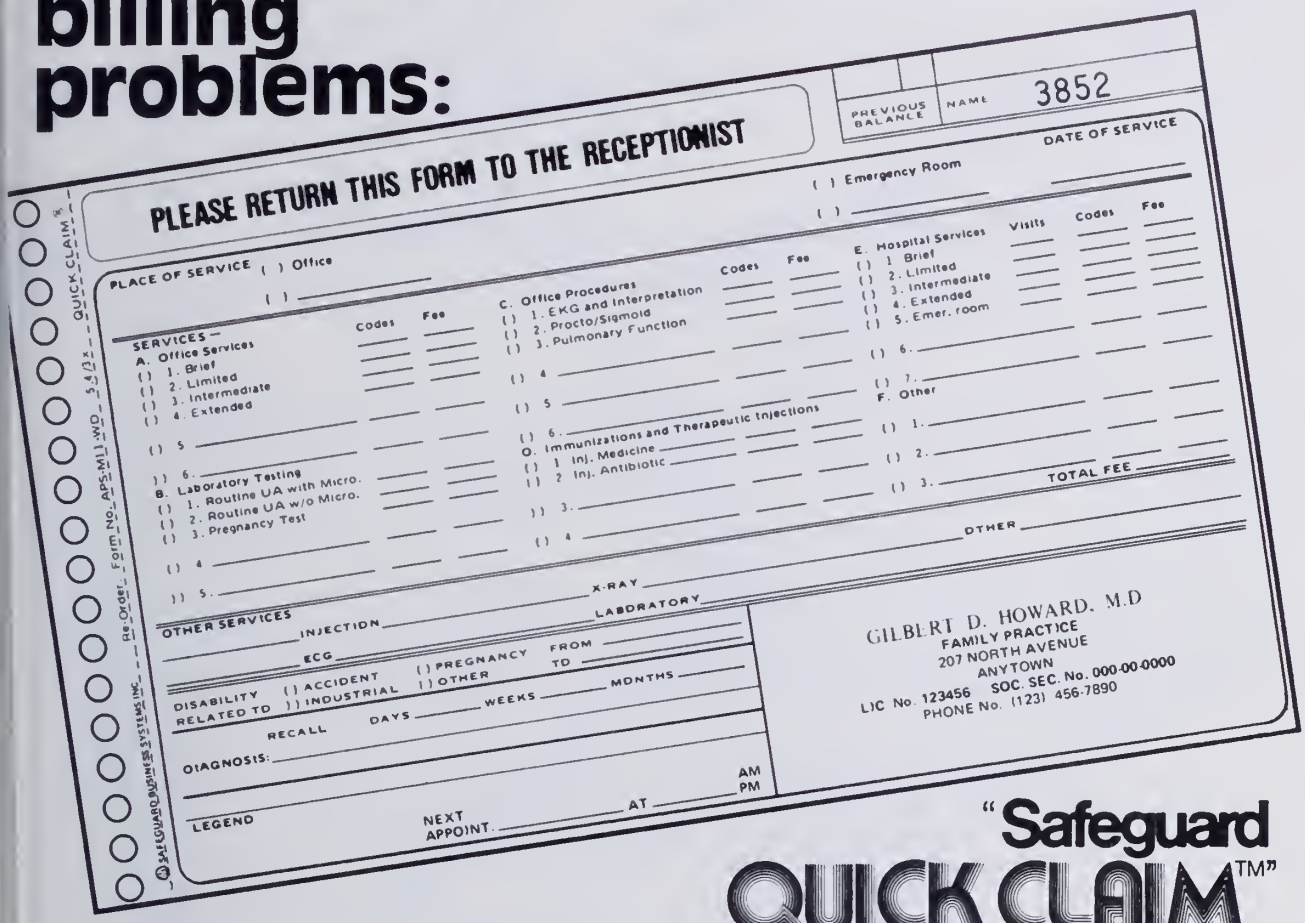

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A public relations success story

Richard A Henry, MD,* Chippewa Falls
Member, SMS Commission on Public Information

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The exposure is through public service announcements, radio and television talk shows, and newspaper articles. The public service announcements are 30-second health tips for better living. Legionnaires disease, acupuncture, and fetal alcohol syndrome have been some of the health topics discussed on radio and television.

The newspaper is the most frequently used medium. Articles have been about pathology, alcoholism, heart disease, and immunizations as well as some controversial issues like unnecessary surgery.

Recently, a series of general information articles about cancer which quoted Chippewa area physicians appeared in the local newspaper. Some of the physicians have received national coverage. Perhaps you have read the stories about efforts to save an 11-year-old boy who was submerged in cold water for upwards of 30 minutes last winter. A couple of the physicians involved in the case will be included in a film about the boy being done by a national television program.

Granted, the cold water rescue was a rare occurrence and of media interest. All other coverage has been the result of not passing up opportunities and because of a relationship with the media based on mutual cooperation and respect.

In Chippewa Falls, we have relied on some basic principles to achieve media coverage. Unquestionably, the media in Chippewa Falls are different from those in larger communities. Both have advantages and disadvantages. But despite the differences, the guidelines we have used can be applied to media in almost any community.

We began with the premise that the general public wants to know more about health. Readership surveys support this premise and indicate that "how to" or coping-type articles are especially in demand. Physicians can provide this advice and service.

Our suggestions for acquiring media coverage are:

(1) Get to know and use the public relations person in your hospital. The public relations person is responsible for projecting a positive, progressive image of the hospital. Remember, physicians are a vital part of any hospital's image.

Public relations people nowadays are generally skilled in media work. They know people within the media, what their demands are, what makes a good news story or feature, and how to prepare copy.

Unlike some reporters, most PR people do not object to having copy proofread before it is released. In this way, physicians can be assured the information is accurate. Another advantage of PR people is that they can make arrangements for a physician to be interviewed and provide media with advance information.

(2) If your hospital does not have a PR person or it is not feasible for you to work with that person, then get to know people within the media. In smaller communities, physicians should get to know the newspaper editor and radio and television news directors. Many metropolitan or larger daily newspapers have reporter(s) who specialize in health. Talk to those people, establish a rapport with them and begin feeding them ideas. Be careful, however, not to exert too much pressure or be patronizing because reporters tend to become irritated or suspicious.

(3) Learn what the needs of the media are. A PR person can provide this information or otherwise talk with members of the media. Be straightforward with them and you will find many media people willing to help.

(4) Because of the interest in health, physicians are a "gold mine" for stories. If you have an

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idea for a story, decide which media would be appropriate. Many times, especially when the story idea is presented properly, all media can be used and maximum exposure attained. For example, a story on immunization can appear in the newspaper, be discussed on a radio or TV talk show, and promoted through public service announcements.

Always remember that weeklies and small dailies are very interested and more apt to use stories that have a local angle. The local angle can be achieved by rewriting a story and quoting a physician who lives and works in the community.

Another rule of thumb to remember is to present the information so that the vast majority of people reading or listening understand it. If possible, avoid medical terminology. Also, keep the information brief and to the point.

These are some guidelines that have worked well for physicians in Chippewa Falls. It must be remembered that all media coverage about health will not be positive. However, if you have developed a good working relationship, it is not uncommon for a reporter or editor who receives a derogatory story to seek your input.

A final note, if a reporter did a good story, don't hesitate to let him or her know. We all appreciate an occasional thank you. ■

VA Vocational Rehabilitation

The VA is seeking federal legislation that will allow expansion of the VA vocational rehabilitation program. The agency would like to provide direct job placement services as well as to utilize such services from other governmental agencies and nonprofit organizations. The VA also would like to remove the eligibility time limits for all service-disabled veterans who are otherwise qualified for and in need of vocational rehabilitation because of such disabilities. ■

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER
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AND ITS HEALTH SERVICES DIVISION

Tanning salons, a skin cancer threat

A NEW ENTERPRISE—commercial sun-tanning salons—is rapidly becoming popular in the United States. Recently a committee of dermatologists with a special interest in photobiology became concerned and issued a strong statement urging physicians to warn the public about the potential dangers of these establishments.

The fad began in 1978 when Grady Mason, a real estate broker, opened the first American salon in Searcy, Arkansas. The Food and Drug Administration estimates that there are over 1000 tanning salons now in operation. They are located in most states including Hawaii and also Canada and England. Several are known to be in operation in Wisconsin.

A minute in a booth is equivalent to an hour in the sun without the heat, perspiration, and sand of a beach. A base tan can be achieved by visiting the salon every other day for ten days, followed by two visits a week to maintain the tan. Usually a new customer will be asked to fill out a questionnaire. Depending upon the client's skin characteristics, the operator will recommend the length of exposure to be given. A pair of plastic goggles is used to protect the eyes. After undressing, the customer goes into the tanning booth where the length of exposure is controlled by an employee. Although it is possible to receive just one treatment, more commonly 10-20 visits are encouraged, and annual memberships are available.

Frederic Mohs, MD, a physician who specializes in chemosurgery and treats many patients with skin cancer at the Center for Health Sciences in Madison, is very concerned that the current fashion to be tan will cause many skin cancers to develop in the future. Skin cancer is already a serious problem for Americans, with about 400,000 developing each year (although it is hard to obtain accurate figures for many skin cancers are never reported). This means that about a third of all cancers arise in the skin. And it is not always easily treatable—approximately 6200 (4600 melanomas; 1600 other types of skin cancer) people die annually of this type of cancer.

Before 1930, skin cancer was not very common; today it is almost an epidemic. It develops primarily on those areas of the skin which are excessively exposed to the sun, such as the face, neck, arms, hands, legs, and back. The increased incidence has been largely due to changes in style of clothing and customs which allow exposure of large areas of skin. A well tanned skin is now a status symbol indicating that one has the time and/or money to lie in the sun.

The panel of dermatologists warned that "tanning for cosmetic purposes is not a safe or innocuous procedure." The ultraviolet light in the sun is the factor that damages the skin. The light sources used in these salons are Sylvania or Westinghouse tubes (FS-40) which produce light that is almost 70% ultraviolet in the 280-320 nanometer range—the range most dangerous as a skin carcinogen. Repeated exposure to such rays may have a cumulative damaging effect on the skin which can cause chronic actinic damage that will lead to dry leathery skin, loss of connective tissue support, and in time precancerous keratoses and cancer. The danger is greatest for fair, thin skinned, sun sensitive people.

An additional concern is that customers are not examined before exposure by a competent physician familiar with skin diseases. Anyone with a photosensitive disease such as lupus erythematosus or vitiligo should not be treated, but they may be unaware of their condition. Also some medicines (such as chloroquin, tetracycline, or griseofulvin) are photosensitizing and persons taking these medications should not visit the salons.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or the State Medical Society of Wisconsin, Health Services Division, PO Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

It has been estimated that a pale-skinned person who spends a good deal of time outdoors, sunburns easily, and has an estimated life time exposure of over 30,000 hours of sunlight will have a twenty-fold greater risk of developing skin cancer than a person who receives less than 10,000 hours exposure. With the more concentrated exposure delivered at such salons, a person may quickly receive a carcinogenic dose of ultraviolet light.

Because these salons are new, there are few state and federal regulations about how they are operated. Usually the person has no idea of the amount of radiation he is receiving. A new bulb may provide more radiation than an older bulb. Also a few accidents have occurred when the client slipped and fell against a bulb and was cut or burned.

Shortly the Food and Drug Administration will require salons to have protective guards around the sunlamps and on-off switches in the booths and sunlamp manufacturers to provide warning labels about the hazards of overexposure and the need for protective goggles, timers, and other controls.

Patients should be warned about the hazards of such exposures. Also, if they must be in the sun for extended periods, they should be advised to use a sunscreen lotion or cream which will protect them from the direct rays of the sun and block out rays reflected from sand, concrete, snow, and other reflecting surfaces. Preparations containing 5% PABA (para-aminobenzoic acid) or PABA esters are the most effective, but benzophenones and other chemicals are available if PABA cannot be tolerated or if the patient objects to possible staining of clothes by PABA. Other precautions such as protective clothing and umbrellas should be taken by sensitive individuals.

Skin cancer is undoubtedly the cancer which can be most easily prevented if people would only avoid overexposure to the harmful effects of ultraviolet light and have precancerous keratoses removed before they progress to cancer.

—**Dorothy J Buchanan-Davidson, PhD**
Science Writer ■

LETTER OF THE WEEK—Suntan parlors

In an era of increased health awareness, physicians are making an increased effort to practice preventive medicine and to educate the public about health hazards.

It is ironic, considering this attitude, to observe the popularity of "sun-tan parlors" as a business supposedly promoting healthful skin.

Physicians have long been aware of the adverse effects of ultra-violet light on the skin. Whether natural from sun exposure or artificial from sun lamps, ultra-violet light leads to premature aging of the skin and an increased risk of developing skin cancer. The public should be aware of these risks before patronizing "sun-tan parlors."

Skin damage is cumulative. Two minutes under a sun lamp or two hours of summer sunshine will not cause skin cancer anymore than two packs of cigarettes will cause lung cancer. But the same exposure to known carcinogens over 20 years could.

Many variables are present. A fair-skinned person with red hair and blue eyes who always sunburns has a much higher risk in developing skin damage and cancer from ultra-violet light than a dark-skinned person who rarely sunburns. Individuals with certain diseases aggravated by ultra-violet light or persons taking certain light-sensitizing medications should not patronize "sun-parlor establishments" or Miami Beach for that matter.

On the other hand, physicians have beneficially used ultra-violet light in a controlled manner in treating skin disorders such as psoriasis. As physicians, it is our responsibility to judge whether its benefits outweigh the risks in an individual patient.

Persons need to reassess the misconception that tan skin is healthy skin and realize that being a "bronze beauty" may in fact make you a "wrinkled prune" with skin cancer in years to come.—**Hal Ridgeway, Donald Schuster and Hubert Moss, M.D.s, for the Public Relations Committee, Dane County Medical Society, Madison. (Reprinted with permission from *Wisconsin State Journal*, April 12, 1980, and the authors)**

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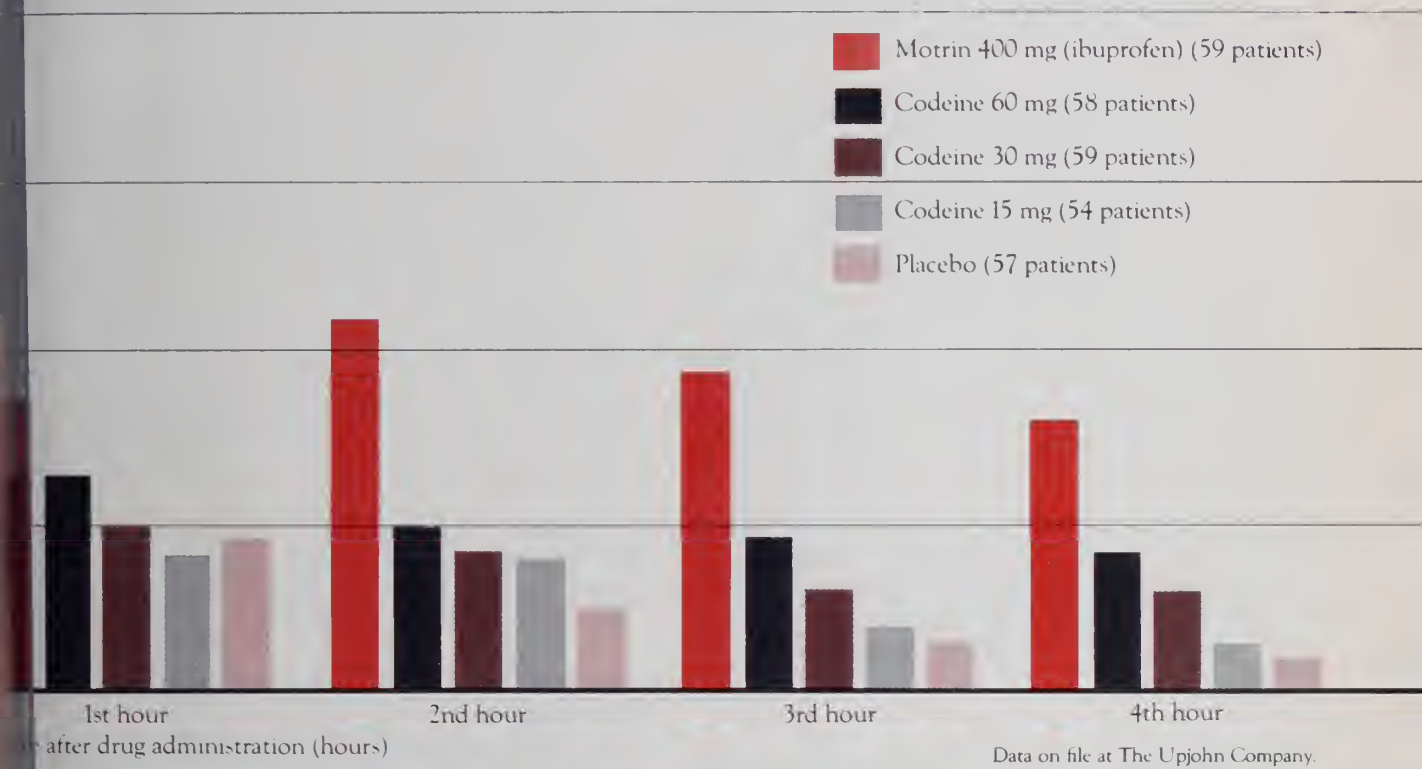

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Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Emergency Service Physicians needed for emergency service in a 125-bed hospital along the shores of Green Bay. Excellent recreational activities. Salary $60,000+, malpractice paid, other benefits. Looking to start small ER cooperation with unique time off and vacation periods. Write or call: Tom Mack, MD, 1312 16th St, Menominee, Mich 49858 or Robert Cegelski, Admin, Marinette General Hospital, 3100 Shore Drive, Marinette, Wis 54143. Phone: 715/735-6621. p5-6/80

Family Physician—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

Wanted: General Surgeon needed to join group of three Board Certified Family Practitioners. Present surgeon in group retiring after 24 years of excellent established practice. Cumberland is a lovely city of 2000 surrounded by lakes. Six-man clinic adjacent to remodeled 47-bed hospital and new surgical suite. Minneapolis, St. Paul, and Eau Claire each 80 miles away. Contract negotiable. Corporate member in one year. Contact D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 5-7/80

Board Certified or Eligible Pediatricians for full or part-time positions in teaching hospital and medical school affiliated community ambulatory care center. Appointees will work as members of existing primary care group of faculty pediatricians and internists. Positions immediately available, starting date flexible. Faculty appointment in the Department of Pediatricis, Medical College of Wisconsin. Competitive salary and fringe benefits. Wisconsin licensure required. Contact G A Limbeck, MD, Director, Department of Pediatrics, Milwaukee County Medical Complex, Box 148, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-6392 (collect). p6-8/80

Family Practice position wanted. Board certified, residence trained family physician seeking position with established group in metro Milwaukee area. Please send inquiries to PO Box 13582, Wauwatosa, Wis 53226. p6/80

Surgeon-General/Vascular, noncardiac chest. Position available with a 16-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, hospital, educational, civic advantages. Please call collect or write: B J Stochr, MD or W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Phone: 414/494-5611. 4-7/80

Wanted. Board Certified or Eligible OB/GYN; immediate opening with 8 physicians; multispecialty group of 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon. Clinic building is next to community hospital; expanding service area in western Milwaukee metro fringe location; first-year salary with optional second-year corporate stockholder; excellent fringe benefits including pension and profit-sharing plans. Contact J L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone 414/673-5745 collect. 5tfn/80

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Family Practice
- Cardiology
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

General Practitioner and General Practitioner with surgery urgently needed to serve Northwestern North Dakota community with service area of 7000 population. Recent 25-bed hospital, excellent three man clinic. Good schools, no crime, great hunting and fishing. May work for salary or lease with option to purchase clinic. Call collect 701/965-6384, Sister Juliana Schwab, Admin, St Luke's Hospital, Crosby, ND 58730. 5-6/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Neurologists: Board eligible or certified neurologists sought for practice with busy neurosurgical group. Prefer experience with EEG and EMG. Excellent starting salary and fringe benefits. Contact Dept 472 in care of the Journal. 11tfn/79

Medical Emergency Service Associates (MESA), SC has immediate openings for qualified Emergency Physicians in a northwest area close to Chicago which is an ideal setting in a new progressive hospital. The community offers an excellent school system and many community activities. It is a short distance from all of the cultural offerings in Chicago, as well as driving distance to water sports, hunting, fishing, and many winter activities. This is a perfect opportunity for a physician and his family. MESA offers salary computed up to $84,000 annually, excellent working conditions, flexible scheduling and fringe benefits, plus the opportunity to join a stable, growing corporation dedicated to providing quality emergency medical services. Send your CV or telephone: MESA, 188 Industrial Drive, Suite 316, Elmhurst, Ill 60126; Miss Barten, telephone 312/832-4504. MESA would like to be a part of your future. 4-6/80

1980 MERCEDES-BENZ 300D Diesel 4-door sedan automatic, AM-FM stereo-radio, automatic antenna, air condition, cruise control, electric sunroof/window, front center arm rest, alloy wheels, coco-mats, central locking, only 2,300 miles, warranty to 24,000 miles and transferable! An exciting automobile at 27mpg. Best offer. MUST SELL. 414/278-7405 office, or 414/962-3231 residence. p6/80

General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

Wanted—Family Physician to associate with four family physicians and two general surgeons to work in a satellite clinic with another family physician. 12 miles from Fond du Lac, Wisconsin, a community of 37,000 located on Lake Winnebago in the heart of Wisconsin's agricultural and recreational area. 60 miles from Milwaukee, Green Bay, Madison. Rotation of night and week-end call with four family physicians. 300-bed hospital. Excellent schools, four-year liberal arts college, two-year University of Wisconsin extension. Contact: John U Peters, MD, 505 East Division St, Fond du Lac, Wis 54935. Call collect 414/922-3700 (business) or 414/922-7899 (home). 4-7/80

PEDIATRICIAN—To join 5-man department in a multispecialty clinic, practicing general and consultative pediatrics. Northeastern Wisconsin community of 50,000 with referral base 100,000; excellent medical facilities; referral Intensive Care Nursery; progressive lakeside community. Contact G D Reilly, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Tel: 414/725-7071. 2-7/80

Retiring general practitioner in New London, Wisconsin, has office ready for family or general practitioner. New London has population of 6300 and is located near Green Bay, Wisconsin, and 100 miles from Milwaukee, Wisconsin. Good location for hunting and fishing, excellent school system. Modern and well-equipped facility available to sell. Two upstairs apartments included. Also 100-bed accredited hospital located in the city. Please contact John W Monsted, MD, 616 Wyman St, New London, Wis 54961. 6/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Wanted General Psychiatrist. Private practice. Northern Wisconsin community. Central Northwest Psychiatric Clinic. Contact J M Tobin, MD, 2712 Stein Blvd, Eau Claire, Wis 54701. Phone: 715/834-2751. 4-6/80

Wanted: General surgeon to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact Dr William Sybesma, 80 Sheboygan St, Fond du Lac, Wis 54935. 6-8/80

Physicians—Urban Indian health center needs full-time Family Practitioner and a full or part-time Pediatrician to join our medical staff in providing care for the Native American and low-income community in Milwaukee, Wisconsin. Compensation package includes salary, fringe benefits, and paid malpractice insurance. Wisconsin license required. Please send resume to: Personnel Director, Milwaukee Indian Health Board, 930 North 27th Street, Milwaukee, Wisconsin 53208; (414) 931-8111. 6/80

1979 MERCEDES-BENZ 240D Diesel 4-door sedan, automatic transmission, AM-FM stereo, air-condition, cruise-control, sunroof, central locking, radial tires, metal undershield, motor-block heater, 10,500 miles, warranty to 24,000 miles transferable! Beautiful automobile, which gives you 32mpg. Best offer. Call 414/278-7405 office, or 414/962-3231 residence. MUST SELL. p6/80

Medical Facilities

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Office for rent. 926 Milwaukee Ave, South Milwaukee, Wis. Any portion or entire 2nd floor available. 600 to 3600 sq ft. Will divide and remodel to suit. Immediate occupancy. Phone: 414/545-2152. 4-5/80

Allergy and Internal Medicine practice for sale. Immediate occupancy. Milwaukee location. Tel 414/464-4460 or 414/353-6645. 6-7/80

Real Estate

Wisconsin Farms and Recreation Properties.

710—Mazomanie—161 acres of wooded land, presently leased to DNR for public hunting, $200,000; Bill Murphy, 845-8877.

735—Mt Horeb—100 acre farm, trout stream, bass pond, very good buildings, $160,000; Bill Murphy, 845-8877.

701A—Mt Horeb—45 acres, mostly wooded, stream, farm house and buildings, $149,000; Dixie Burns, 437-5736.

320A—Adams—65 wooded acres, bordering Adams County airstrip, property has man-made pond, good hunting, $98,500; Jim Trickey, 244-8820.

604—Adams—300 wooded acres with 100-acre private lake. Develop or keep private, land contract, $265,000; Jim Trickey, 244-8820.

628—Price County—35 wooded acres, $7,000; Jim Leary, 832-4859.

625—Dells area—141 acres with lake, beautiful pines and hardwoods, $200,000; Bill Murphy, 845-8877.

ERA-HALLMARK REALTY, Madison, Wis 608/221-3591 or 274-3350. 6/80

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1978-79 REGISTRY OF PHYSICIANS, PHYSICAL THERAPISTS, PODIATRISTS, AND PHYSICIAN'S ASSISTANTS

This registry is available from the Wisconsin Medical Examining Board, 1400 East Washington Ave, Madison, Wis 53702, at a cost per copy of $3.12. Checks should be made payable to the Wisconsin Medical Examining Board. Physicians no longer receive a complimentary copy due to a recent change in the Statutes requiring that the Board now charge for this registry. ■

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

WISCONSIN—1980

JULY 1: *Geriatric Cardiology,* at Marc Plaza in Milwaukee. Cosponsored by Wisconsin Regional Geriatric Center and Cardiovascular Program of Mount Sinai Medical Center. Featuring Robert Kennedy, MD, British cardiologist and coauthor of *Cardiology and Old Age.* Info: Albert Fisk, MD, Wisconsin Regional Geriatric Center, 2711 West Wells St, Milwaukee, Wis 53208; or phone 414/933-6769.

JULY 20-26: *Fifth Annual Wellness Promotion Strategies,* University of Wisconsin-Stevens Point. Limited enrollment. Info: WELLNESS PROMO V, Fred Leafgren, Student Life-Delzell Hall, University of Wisconsin, Stevens Point, Wis 54481. Phone 715/346-4194 or 715/346-2611.

AUGUST 25-27: *Pediatric Applications of Evoked Potentials* at The Wisconsin Center, Madison. Fee: $200. 17 hours credit Category I of AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

September 12-13: Wisconsin Surgical Society fall meeting, Lake Geneva.

SEPTEMBER 17, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category 1 of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

SEPTEMBER 24-27: *The Fifth Annual Nuclear Cardiology Symposium.* The Red Carpet Inn, Milwaukee. Sponsored by the University of Wisconsin-Extension, Department of Continuing Medical Education, Cardiovascular Disease Program, Milwaukee Clinical Campus, University of Wisconsin-Madison, School of Medicine, American Heart Association—Wisconsin Affiliate, and Society of Nuclear Medicine. Fee: Mini Symposium (Sept 24), $40/physicians; $18/technologists. Conference fee (Sept 25-27), $220/physicians; $85/technologists; $250/1 physician/1 technologist team. 16 credit hours AMA Category I. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

OCTOBER 15, 1980: *One-Day Seminar for Family Physicians,* St Vincent Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category 1 of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

OCTOBER 24-25: *Orthopedics for the Practicing Physician.* Wisconsin Center, and University of Wisconsin Clinical Science Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education, and University of Wisconsin-Madison, School of Medicine, Department of Orthopedic Surgery. Fee: $125. AMA Category 1 credit hours applied for. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

OCTOBER 29-31: *Recent Advances in Diagnostic Radiology for the General Radiologist: Neuroradiology—Ultrasound—Nuclear Medicine.* Wisconsin Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and University of Wisconsin-Madison, School of Medicine, Department of Radiology. Fee: $250 seminars and workshops/$200 seminars only. 22 credit hours Category I of AMA, ACR credit. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Toll free number 1-800/362-9080.

WISCONSIN—1980

NOVEMBER 5-7: *Aging and Illness in Primary Care—Basic and Clinical Science Foundations.* Wisconsin Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and University of Wisconsin-Madison, School of Medicine, Departments of Medicine and Family Medicine and Practice. Fee: $215. 21 credit hours Category I of AMA; AAFP credit. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 6-8: *2nd Annual Respiratory Critical Care Symposium: Acute Respiratory Failure—Admissions to Discharge.* The Inn on the Park, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and the University of Wisconsin Center for Health Sciences. Fee: $150/physician; $100/nurse, resident, allied health professional. 15 credit hours of Category I of AMA and Family Physician credit applied for. 1.5 CEU units. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 12, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

ILLINOIS—1980

SEPTEMBER 5-6: Illinois Congress on Continuing Medical Education, at Oak Brook Hyatt House, Oak Brook, Illinois. Theme: *Does CME improve physician performance?* This particularly urgent question is being addressed because the effectiveness of traditional CME is increasingly being questioned. In response to interest expressed by people from other states, CME planners from outside Illinois are being invited to this year's Illinois Congress. The theme of the Congress will be addressed directly by the speakers at two plenary sessions—Ronald W Richards, PhD, Director and Professor, Center for Educational Development, University of Illinois College of Medicine; and Richard M Caplan, MD, Associate Dean/CME at the University of Iowa. For additional information write or call the Illinois Council on CME at 55 East Monroe, Suite 3510, Chicago, Illinois 60603; (312) 236-6110. The Illinois Council on Continuing Medical Education was established in 1972 jointly by the Illinois State Medical Society and the state's eight medical schools and is supported primarily by contributions from ISMS members.

OTHERS—1980

July 14-16: *NIH Consensus Development Conference on Adjuvant Chemotherapy of Breast Cancer* at Masur Auditorium, Clinical Center, National Institutes of Health, Bethesda, MD. Info: Ms Yvonne Lewis, Prospect Associates, 11325 Seven Locks Rd, Suite 220, Potomac, MD 20854. Phone: 301/983-0535.

JULY 20-23: Hospital Information Systems Sharing Group Summer Seminar, *Clinical Systems in Perspective: An Assessment for the '80s,* at the Lodge at Snowbird, Snowbird, Utah. Info: Jim Bailey at HISSG Office: (801) 972-6099; or 10 South Main St, Suite 331, Salt Lake City, Utah 84101 (801) 531-1717.

July 23-25: *NIH Consensus Development Conference on Cervical Cancer Screening: The Pap Smear* at Masur Auditorium, Clinical Center, National Institutes of Health, Bethesda, MD. Info: Ms Nancy Becker, Prospect Associates, 11325 Seven Locks Rd, Suite 220, Potomac, MD 20854. Phone: 301/983-0535.

AUGUST 20-22: Consensus Development Conference: "Endoscopy: What is Its Role in Upper Gastrointestinal Bleeding?", at Masur Auditorium, National Institutes of Health, Bethesda, Md. Sponsored by the Digestive Diseases and Nutrition Program of the National Institute of Arthritis, Metabolism, and Digestive Diseases. For practicing physicians and experts in relevant fields such as gastroenterology, liver diseases, endoscopy, radiology, and biostatistics. Info: Mrs Billie B Mackey, Digestive Diseases and Nutrition Program, National Institute of Arthritis, Metabolism, and Digestive Diseases, Building 31, Room 9A21, Bethesda, Md 20205 (301/496-6158).

SEPTEMBER 15-18: *American College of Emergency Physicians.* Las Vegas, Nev. Contact: Communications Group, ACEP, 3900 Capital City Blvd, Lansing, Mich 48906.

OCTOBER 19-24: *American Academy of Physical Medicine and Rehabilitation,* Washington, DC. Contact: Barry Miller, PO Box 995, Ann Arbor, Mich 48106, 313/572-3562.

OCTOBER 19-24: *Annual Clinical Congress, American College of Surgeons,* Atlanta, Georgia. Info: ACS, 55 East Erie St, Chicago, Ill 60611; (312) 644-4050, ext 324.

OCTOBER 24-26: *American Academy of Neurological and Orthopaedic Surgeons.* Contact: Michael R Rask, Program Chairman, 2320 Rancho Drive, Suite 108, Las Vegas, Nev 89102.

OCTOBER 26-30: Annual Scientific Assembly of the American College of Chest Physicians, at the Sheraton Boston Hotel and Hynes Auditorium Convention Center, Boston, Mass. *CAT Scanning—Cardiopulmonary Disease* and *Detection, Diagnosis, and Management of Lung Cancer* are two of the six subjects to be discussed in the major symposia sessions. Full-day programs discussing such topics as occupational lung disease, critical care, perfusion technology, respiratory care, and echocardiography will be presented. Over 30 hours of credit may be obtained toward Category I of the PRA-AMA. Further info: Dale E Braddy, Director of Education, ACCP, 911 Busse Highway, Park Ridge, Ill 60068.

AMA—1980

JULY 20-24: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 7-10: Interim AMA House of Delegates, San Francisco Hilton, San Francisco, Calif.

AMA—1981

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9: Interim AMA House of Delegates, Las Vegas Hilton, Las Vegas, Nev.

AMA—1982

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8: Interim AMA House of Delegates, Fountainbleu Hilton, Miami, Fla.

MEDIGAP HOTLINE: 1-800-362-3930

Designed to answer health insurance questions.

- **Health insurance and retirement**
  How will my insurance needs change when I reach 65?
  What is a Medicare Supplement policy?
  How do different policies compare in coverage? In cost?
  What policies are currently on the market?
- **Health insurance for those over 65**
  Do I have good health care coverage?
  Am I paying for too much insurance?
  Can I replace my policy with a better one?
- **Special kinds of health insurance**
  Are cancer policies worthwhile?
  How do indemnity policies work?
  Do I need a nursing home policy?
- **Medical Assistance (Medicaid, M.A., Title XVIX**
  Am I eligible for Medical Assistance?
  Do I need private insurance with M.A.?
  What does M. A. cover?
  Where do I apply?

Medigap Hotline is a project of the Center for Public Representation in Madison. It is available to Wisconsin residents over age 65 or approaching retirement. When the Hotline is not in operation, a recording will give the scheduled times for calling.

Wisconsin Weight Loss Guide

A 22-page booklet developed by a registered dietitian to be consistent with current nutrition practices. It was written for adults, 19 years of age and older. The calorie levels for men and women vary, depending upon the type of milk the individuals choose to consume. The emphasis of this guide is on the combination of modifying eating behavior with the consumption of a nutritionally adequate, low-calorie diet. The booklet is available without charge from the **American Dairy Association of Wisconsin,** 4337 West Beltline Highway, Madison, Wisconsin 53711. Indicate the quantity desired.

SMS Publications Pricing Policy

The State Medical Society provides many brochures and reports for physicians, their patients, and the public. Some of these are prepared and printed at the SMS headquarters in Madison; others are obtained from, or funded by, outside sources. With distribution and printing costs continuing to spiral upward, the Society has found it necessary to establish a pricing policy to cover its costs . . . as follows:

(1) On priority (newly developed) brochures, each SMS member physician is entitled to 200 free copies. Additional copies will be charged on a per cost basis.

(2) Nonmember physicians, outside agencies and organizations will be charged on a per cost basis including a $3.00 minimum charge for postage and handling. Ten complimentary copies will be sent free of charge.

(3) On materials funded by an outside source (*eg,* Rubella brochure was funded by a health insurance company) SMS will pay for distribution (postage and handling) as a public service.

SMS patient publications (cost, plus 4% sales tax):

1. Rubella (red measles mini-brochure): 1¢ each
2. Alcohol and Your Unborn Baby (mini-brochure): 1¢ each
3. Operation Lifestyle (brochure): 3¢ each
4. Partners in Good Health (brochure): 3¢ each
5. Partners in Good Health (statement stuffer): 2¢ each
6. Partners in Good Health (poster): 5¢ each
7. I Want to Know What You Think (patient questionnaire): 3¢ each
8. I Want to Know What You Think to Your Good Health (brochure/medical care costs): 3¢ each
9. If You Have a Complaint About Medical Care (brochure): 6¢ each

Requests for the above items should be sent to: SMS Communications Dept, Box 1109, Madison, Wis 53701; or phone 257-6781 (Madison area) or toll-free 1-800-362-9080 (in Wisconsin).

PHYSICIANS: Are you receiving more and more questions about nutrition?

Subscribe *now* for your *free* subscription to **THE DAIRY COUNCIL DIGEST.** The Digest is a bi-monthly publication of the National Dairy Council which condenses and summarizes current nutrition research. Just fill out the form below and mail to: The Dairy Council of Wisconsin, 12345 W Capitol Drive, Milwaukee, Wis 53222.

YES, I would like to receive a free subscription to The Dairy Council Digest. Also send me a free copy of the Dairy Council's Catalog of nutrition education material.

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News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

SUGGESTED LETTER OF WITHDRAWAL FROM CASE. The State Medical Society has prepared a suggested letter that physicians might use for withdrawing from a case when the patient consistently uses abusive or abrasive language to personnel, or is unruly in conduct or has a history of financial irresponsibility. The suggested letter appears in this BLUE BOOK issue adjacent to the article on "Consent and Related Forms."

CONFERENCES SLATED ON ESTABLISHING HOSPICES. The American Hospital Association invites physicians to attend an educational program on hospice care it is sponsoring at three different locations in 1980. "Hospital-Based Hospice Care: Program for Decision Makers" is scheduled for June 26-27 in Boston, MA; September 25-26 in Lake Buena Vista, FL, and October 13-14 in Denver, CO. The Program will focus on questions most often asked when an institution's decision makers contemplate establishing a hospice program. For further information, contact the Division of Education, American Hospital Association, 312-280-6083.

PHYSICIANS MAY ADVISE PATIENTS ON CHIROPRACTIC. Wisconsin Attorney General Bronson LaFollette has ruled that the Medical Practice Act, ch 448, Stats, permits a physician, subject to certain limitations, to advise a patient whether continued chiropractic care is necessary. While the giving of such advice may technically fall within the definition of chiropractic practice, it does not constitute the unauthorized practice of chiropractic. The Attorney General had been asked to rule on the issue at the request of the Chiropractic Examining Board.

BENEFITS INCREASED UNDER SMS MEMBER HEALTH INSURANCE PLAN. SMS Services, Inc has announced an improvement in the already excellent coverage offered by the SMS Medical Protection Plan which is underwritten by Blue Cross-Blue Shield United. The maximum number of hospitalization days under the basic coverage has been increased from 120 days to 365 days. Premium rates remain the same.

CORRECTION. In the May issue's NEWS YOU CAN USE, page 72, the article entitled **CHEAP MONEY** contained an error, stating that WHCLIP offers an optional deferred payment plan which calls for a 60 percent down payment, an additional 20 percent in 90 days, and the final 20 percent in 180 days. The sentence should have stated: WHCLIP offers an optional deferred payment plan which calls for a 40 percent down payment, an additional 30 percent in 90 days, and the final 30 percent in 180 days.

THE 'E' IS NOW GONE FOR HEW. On May 5 the Dept of Health, Education, and Welfare officially became the Dept of Health and Human Services (HHS), when the new cabinet-level Dept of Education opened for business with 17,000 employees and a budget of $14 billion. By the way, the Dept of Health and Human Services' budget is the third largest in the world, falling only behind those of the entire U.S. government and the Soviet Union. Its current spending level of $220 billion is applied to about 300 programs and run by 140,000 full-time, permanent employees.

X-RAY LICENSURE, MINIMUM BENEFIT BILLS VETOED. Governor Dreyfus has vetoed bills calling for licensing of x-ray machine operators in the state and establishing minimum benefit levels for disability insurance policies. SMS had supported Assembly Bill 437, the minimum benefits bill, during the last legislative session and, in fact, had the bill introduced in 1975. In vetoing the x-ray certification bill, AB 824, the Governor said he was not convinced that licensing x-ray operators would result in better health care for Wisconsin citizens or prevent x-ray overexposure. The Legislature was to reconvene on May 28 to act on these and other vetoes. ■

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WISCONSIN MEDICAL JOURNAL

JULY 1980

• The validity of chiropractic • Health care in Tanzania, East Africa • The closing of a Physician's Assistant Program • Revised State Immunization Law • The hemolytic-uremic syndrome in Wisconsin • Increase in cesarean deliveries in Wisconsin • Statewide impaired physician program created

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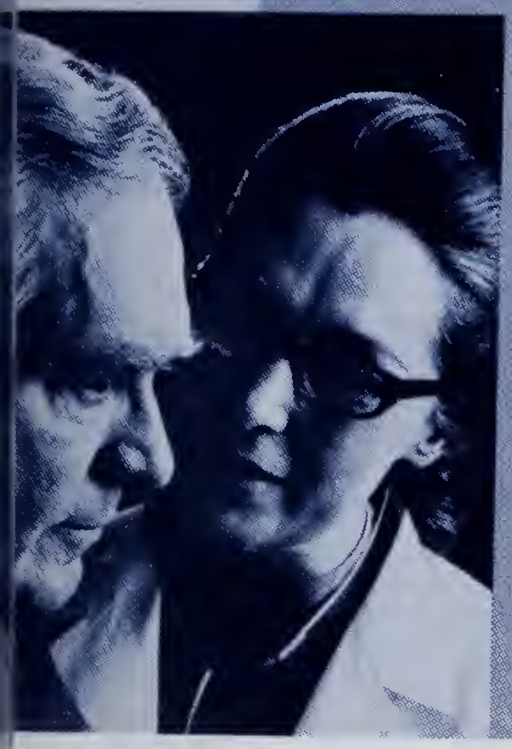

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

The validity of chiropractic

LAST SPRING, frustrated at the recurring strife over health insurance coverage for chiropractic and at the several lawsuits over chiropractor—physician relationships, the First Councilor District submitted the following resolution for consideration by the House of Delegates:

> WHEREAS, From its beginnings, doubt has been cast on the validity of chiropractic as a healing science; and
>
> WHEREAS, Because of the questions raised regarding the validity of chiropractic, organized medicine has avoided establishing professional relationships with chiropractors; and
>
> WHEREAS, The lack of communication and professional interchange between medicine and chiropractic has led to controversy and costly litigation between these two disciplines; and
>
> WHEREAS, The strife between medicine and chiropractic cannot be resolved except on scientific grounds; and be it
>
> *Resolved,* That the State Medical Society urge that the Wisconsin Legislature, through its regulatory bodies, instruct the University of Wisconsin to conduct a complete study of chiropractic to determine its validity and submit its report to the Legislature following completion of the study.

The Reference Committee recommended that the resolution not be adopted, citing that the Governor's Health Task Force conducted such a study in 1972, and its findings remain available to the Legislature and the public.

In the argument on the floor, however, it was pointed out that the Governor's Task Force had reviewed chiropractic theory and instruction methods, but had not conducted tests to establish the scientific basis of chiropractic. Largely on that basis, the recommendation of the reference committee was defeated following discussion, and the resolution was adopted.

Thus far action has been postponed pending development of a method of presentation to the Legislature.

Perhaps it's just as well.

After all, the chiropractic question is not just a Wisconsin problem; it affects all of the states, and the State of Wisconsin should not have to bear the full responsibility (and the cost) of its solution. Furthermore, it may well be that the University of Wisconsin is not the right facility for performance of the necessary experiments. A federally financed and staffed laboratory would seem more appropriate. The findings following completion of the study might be a bit harder to ignore, as well, if the report originated in Washington.

The House of Delegates, next March, should change the final paragraph of the resolution to read as follows:

> *Resolved,* That the State Medical Society urge that the Secretary of the US Department of Health and Human Services contract with an appropriate agency to conduct a complete study of chiropractic to determine its validity and submit its report to the Congress following completion of the study.

The revised resolution will be presented to the Council in July and reintroduced at the House of Delegates next March.

Let's hope that would clarify the situation once and for all. -WJB

CME motivation

THERE HAS been continuing debate not only over the effectiveness of continuing medical education but the question was raised as to why physicians do attend CME courses. A recent report in the AMA Continuing Medical Education Newsletter[1] points out that the relationship between such attendance and the quality of care has remained largely unproved. However, the authors conducted a study[2] of the motivation for attendance and found the results of interest.

All physicians who attended seven CME refresher courses at a Canadian university medical center during one year were asked to complete a questionnaire at the end of each course. The majority of the participants were in general practice or family medicine.

Quality of care was the reason given by 81% of the physicians, and 70% wanted to gain general knowledge and review old knowledge. Past CME experience was the motivation for 40%, and 32% felt that attendance gave them an opportunity to assess themselves. Only 23% attended for study credits and 19% wanted to be in contact with their peers. Social reasons were listed by only 9% and

included in this 4% indicated they wanted to get away from their practices.

The report concluded that it would appear that physicians believe that CME events have an impact on the way they practice and that they value this type of education for stimulation and the potential effect on health care that such education affords.—VSF

REFERENCES

1. June 1980, Vol. IX, No. 6
2. SMS members can obtain a copy of this study upon request to the Scientific Affairs Coordinator at SMS headquarters in Madison: 257-6781 or toll-free 1-800-362-9080.

A national semanticist?

THE FOOD AND DRUG Administration has recently initiated a program to remove proprietary and patent medicines from the drug store shelves unless they are proven to be effective. All of this is being done under the name of protecting the consumer from himself. There are many patent medicine outlets in the grocery stores, supermarkets and even cocktail lounges. It is not enough that a drug is simply not dangerous, but it is also required to be effective according to the latest FDA efforts.

Exactly how you determine the effectiveness of a cough medicine is not explained in the FDA directive. How about fluoride in toothpaste? Is it measured in hours, weeks, years or generations? Certainly, there should be some time limit on demonstrating ineffectiveness or the converse.

Other federal bureaucracies devote their attention to "truth in advertising" and "truth in labeling." While the advertisement may not be untruthful, it is simply not fully informative. "The pain reliever that doctors prescribe most" is aspirin. "The nighttime pain reliever" and the "extra strength pain reliever" contain twice as much of this pain reliever as do the "leading brands." Pure nonsense!

Should not this same nitpicking federal quest for "effectiveness" and for "truth" be applied to legislation? Various pieces of legislation have been introduced in the Congress over the past decade all of which have optimistic if somewhat deceptive words within their titles. Does the Pension Reform Act actually reform anything? Could it be passed if it were simply called The Pension Act? There has been a number of bills such as the Welfare Reform Act, Clinical Laboratory Improvement Act, Election Reform Act, and the Windfall Profits Tax. Another piece of pending legislation is National Health Insurance.

A review of the legislation that has been enacted from some of these bills would reveal immediately that most of them are not effective. Most are, in fact, deceptive. While welfare may have been changed, it is hardly reformed. The Clinical Laboratory Improvement Act has improved nothing. Its only effect has been to complicate the legislation under which laboratories must operate. Both national political parties regret many of the items in the Election Reform Act which allows wealthy candidates to refuse federal matching funds and to outspend their rivals. The act also favors incumbents who have congressional franking privileges for bulk mailings.

National Health Insurance is a misnomer because in actuality it would be a national sickness indemnity neither funded nor actuarially sound as required of insurance companies. In fact, "insurance" identical to Social Security would not be legal in any state in the union if offered by private underwriters. The Windfall Profits Tax is an excise tax on petroleum products paid for by you know whom.

Therefore, what is needed is one more bureaucrat. He would be the official, national legislation semanticist. His job would be to take the extraneous, hopeful, beguiling, endearing adjectives out of legislative bills. He would also require bills to state more correctly what they will actually accomplish. This would result in legislative bills such as the Petroleum Excise Tax, National Sickness Indemnity Act, the Welfare Redistribution Act, etc. These legislative bills may then avoid criticism from the folks in charge of monitoring deceptive labeling but may not be able to pass muster for their efficacy. -RAM

Second opinion

WISCONSIN almost had its own Chad Greene case with a seven-year-old girl suffering from leukemia. The Madison *Capital Times*, in its continued investigation of the Necedah cult, reported this story.

The child was originally taken to a Laetrile clinic in Chicago by her parents and fortunately she was referred back to Wisconsin for chemotherapy. After a course of chemotherapy she appeared to be doing well. The father then decided to withhold further treatments and the pediatrician who had been treating her notified the Juneau County Social Services to begin determination of the child's legal status.

The patient's family are members of the Necedah Van Hoof Shrine Cult, based on the alleged visions of the leader, Mary Ann Van Hoof. Dur-

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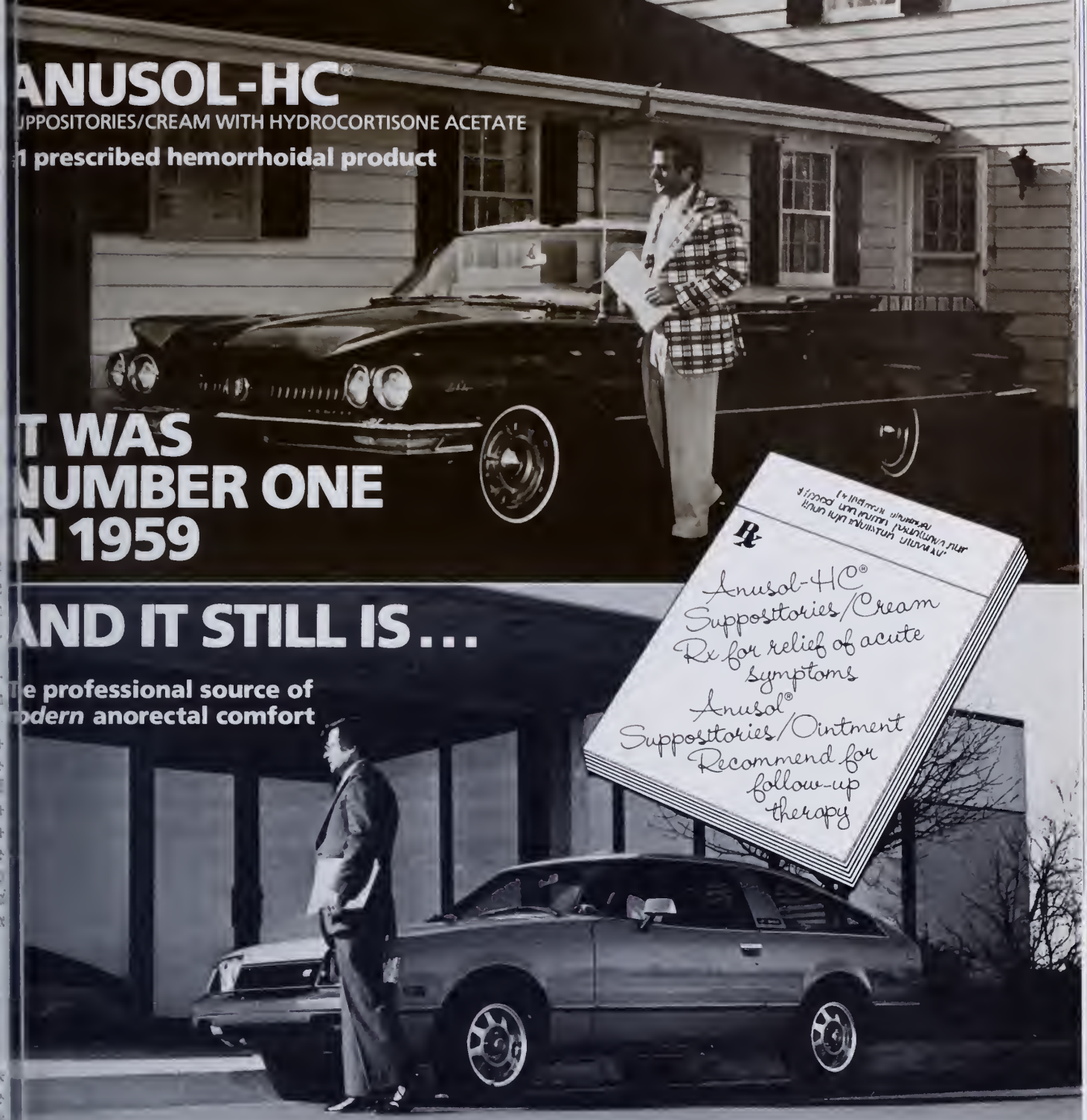

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ing one of her reported visions of the Blessed Virgin, Van Hoof offered the following revelation:

"Got to warn against medicine, food, water . . . One group of doctors or scientists produces a medicine to help the sick; the other one comes along and puts neutralizer in to destroy this very medication, just as has been done in the research of cancer by more than one doctor whom is classified as quacks or crackpots, but they had the cure and the knowledge of cancer (it came through our work in 1955 that the AMA has known both the cause and the cure of cancer for more than 25 years. They also know the cause and cure for polio), polio and so many other diseases, but your enemy doctor comes along with neutralizer and neutralizes; or in other words, puts a reaction in the bloodstream to not accept the medications. That is just part of it."

The Juneau County judge ordered a second opinion from a certified pediatric cancer specialist. This resulted in the finding that the child had suffered a relapse. The father then relented and allowed her to be taken back to Madison for continued treatment. Although early this year the chances of complete recovery for the youngster were 70%, the prospect after this relapse dropped to less than 20%.

With a second opinion and advice coming from revelations on high, it is an uneven contest for terrestrial physicians with only scientific medical backgrounds.

The patient's father maintains the child can be cured with wheat germ and other natural foods. The cult leader encourages members to be skeptical about the doctors. The hierarchy of the cult includes not only the uneducated woman with her alleged visions, but also a self-ordained archbishop who was convicted in Maryland last February of sexually molesting an 11-year-old boy and sentenced to five years probation, an attorney who is constantly available to leap to the defense of the cult members, and a Wisconsin physician.

It is essential that the State Medical Examining Board and the State Department of Health and Social Services maintain a continued surveillance of this cult.—VSF ■

NEWS YOU CAN USE

WATER MINERAL STUDY TO SEEK PHYSICIAN ASSISTANCE. In August Oak Ridge National Laboratory, under authority from the Environmental Protection Agency, will begin a major study of Wisconsin dairy farmers. The study is designed to investigate possible relationships between disease risk and mineral elements in water. Wisconsin dairy farmers have been chosen as the cohort for study because their drinking water is largely obtained from individual wells. Physicians may be asked to respond to a questionnaire as a followup of a death involving a dairy farmer. The physician will be requested to provide epidemiological information as to any cardiovascular disease condition which may have been diagnosed in the deceased. This information is intended to supplement information contained on the death certificate. State law permits the release of such information without the consent of the deceased's next of kin when a request comes from a federal or state agency exercising a properly authorized function. This condition is met by the fact that the study is under the control of the Environmental Protection Agency and is being conducted by the Oak Ridge National Laboratory. The SMS Committee on Environmental and Occupational Health supports the study and urges the full cooperation of Wisconsin physicians with it.

HOSPITAL DISCHARGE SURVEY COMING. The Wisconsin Division of Health is currently preparing to conduct a Hospital Discharge Survey in September 1980 and March 1981. The last survey was conducted in September 1976 and March 1977. The Wisconsin Hospital Discharge Survey is a timebased sample of hospital records of patients discharged from general hospitals. The survey collects information on medical diagnoses, surgical procedures, and the demographic characteristics of each patient. This survey has become a unique source of morbidity data; government and private agencies, as well as individual hospitals have used this survey data to plan provider services, define health problems, determine patient origin, and assign service areas. The State Medical Society has been advised that the Division of Health will seek the Society's input and comments of the proposed data items when the draft copy is completed. ■

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

CME requirements

YOUR (Wayne J Boulanger, MD) article "The end of the line" really hit the spot since I happen to be one of the individuals described by you. I retired at 70 years of age and moved to Sun City (Arizona) where I have been active in the Sun City Physicians Club. To comply with CME requirements is both costly and hardly well worthwhile since my practice is the curbstone variety. Everyone knows I was a dermatologist so it is just the matter of looking at the spot and making a suggestion. This carries over to my work with the Cancer Society like giving talks on skin cancer. I for one would like to see a special category created which would designate me as "retired." I know the local pharmacies accept scripts that I write as long as they are for me or my immediate family. It is cold outside the CME borders. I thank you for a provocative article, and I am certain that a number of retired physicians feel the same way that I do.

—Sture A M Johnson, MD
10306 Hutton Drive
Sun City, Arizona 85351

Retirement problems

IN REFERENCE to your (WJB) editorial, "The end of the line," in the March issue of the Journal, I just want to say thanks. It is nice to be remembered which I didn't think anyone did anymore. Your comments express my feelings very well.

There is quite an adjustment to retiring, and losing one's privilege of being a "doctor." The inability to get a few things at the drugstore without bothering some young doctor for a prescription, or the loss of all those samples once so plentiful but now unobtainable, and the feeling of being no longer a part of a group which one had worked so hard to achieve, is a bit traumatic.

Fortunately, I still have the *Wisconsin Medical Journal* and the *JAMA* to give me some contact with what is going on. But I am sure that the CME and all its benefits have improved the practice of daily medical care, and that the State Medical Examining Board and the legislators have adequate proof of this when compared to those earlier days when we never looked into "current medical thinking." Perhaps they will be fortunate enough to live to the time where they too will "be retired" at some fixed age by a regulation of their making and thus reap the rewards of their current wisdom.

—R J Sanderson, MD
Rt 3, Box 151
Hot Springs, Ark 71901

Doctor-patient relationship

During my internship, I was involved in an automobile accident while driving home from the hospital late one evening. My car was hit by a young woman who ignored a red light. She was steadfast in her assertion that it was I who was in error. A small crowd gathered while we awaited the arrival of the traffic officer. Popular opinion was divided as to who was at fault, but I felt the majority was on my side. The patrolman arrived and asked the usual questions. When he asked my place of work and occupation and I answered (nearly inaudibly), I lost my supporters in the crowd. I could sense the crowd redirecting its sympathies in favor of the young woman simply because I was a physician.

Why are people so angry at doctors? Dr Maurice Fox had good answers to the question (*Newsweek* January 10, 1977). I agree that people are angry because they feel that their doctors make too much money. Actually, few physicians make more than most corporate executives. Also, patients are disappointed to find that their doctors are unimpressed by the vague, nonspecific problems they complain about. My few years as a physician have shown me that there are many reasons; they vary with the patient, the doctor, and the illness. But there is a fundamental theme. Patients feel they are being cheated by their doctors; cheated in that their expectations of the health care system are not being met, and angry to find that their doctors are no longer willing to accept total responsibility for their patients' health.

Responsibility for these misunderstandings must be shouldered by physicians in that most Americans have virtually no understanding as to how to effectively use the existing health care systems. The medical profession has been remarkably inactive in regard to educating the lay-

man as to what to expect from doctors, hospitals, and other components of the health care system.

A glaring example is the abuse of emergency rooms. Patients are genuinely surprised to find the emergency room physician less than fascinated (even angry) when he or she been called at 3 o'clock in the morning to evaluate a head cold that has been symptomatic for three weeks. Doctors feel that ERs are for emergencies, and the patient is disappointed to find that his persistent cold isn't an emergency, or even interesting. Everyone is angry.

People are also disappointed to find that their doctors are not superhuman, and are not always able to perform superfeats (as perhaps some doctors would have their patients believe). There have been medical near-miracles, to be sure. Patients are disappointed to find that, yes, we transplant hearts, but no, we can't cure colds; and there is precious little we can do for your backache.

Many patients are convinced that somewhere there is a superman-like physician who will recognize their particular complaints as a rare and treatable disorder. This sort of magical wish is rarely fulfilled. The patriarch of a wealthy family was admitted to a university hospital with the diagnosis of acute leukemia, a uniformly rapidly fatal type. The family requested that the "best hematologist in the country" be consulted. This sparked an interesting discussion—who was the best? If such an individual exists, how would he or she be recognized? To satisfy this family's need for this sort of magic, the editor of a standard text in the field was flown in for consultation; he agreed with the attending staff in all respects. Sadly, when the patient died, the family was mystified to find that even America's "best" hematologist could not forestall their father's death.

Today's medicine seems remarkably inept at dealing with minor problems, while there have been remarkable successes in diagnosing and treating catastrophic illness. Patients have difficulty in understanding this disparity. An elderly woman referred herself to my clinic because I had done such a fine job in diagnosing and treating her friend's diabetes. She was angry when I could find no illness to account for her multiple complaints, in spite of an extensive and expensive workup. She was unhappy with my reassurance and advice to live with and accept her minor complaints. She wanted something more than good advice. She wanted a procedure, or at least a prescription for her money. A physician who gives a well-educated and careful opinion may have trouble collecting his fee unless he *does* something. I believe this accounts in part for diazepam's (Valium®) phenomenal success. It is tempting to reach for the prescription pad when you have only reassurance to offer. People don't like to pay for information and good advice, while the best physicians learn after many years that reassurance is often the best they have to offer a troubled patient. Again, the patient's expectations have not been met.

America's bad habits are filling our medical wards. Alcohol, cigarettes, overeating, and underexercise are killing and maiming thousands as surely as the deadly automobile. Those who aren't directly harmed are forced to pay ruinous health insurance rates and taxes to support the care of those made ill by their self-destructive habits. American medicine has ignored too long one of its most important functions—the education of patients enabling them to accept primary responsibility for health. By the time the physician is involved, it is often too late—the lungs are shot, the arteries are ruined, the liver is destroyed. Doctors and patients would get along much better if they would mutually acknowledge the following:

"To ward off disease or recover health,
Men as a rule find it easier to depend on the healers,
Than to attempt the more difficult task,
Of living wisely."—RENE DUBOS

—David G Young, MD
Medical Resident
The Medical College of Wisconsin
Affiliated Hospitals
Milwaukee, Wisconsin

New ICCME Handbook on CME evaluation

The Illinois Council on Continuing Medical Education recently announced publication of its first Handbook on evaluation, *Physicians Improve Performance Through Continuing Education.*

This 80-page Handbook reproduces eight studies published during the 1970s that report changes in clinical performance as a result of physician learning (and in one case, improved patient outcomes). It includes also: (a) an analysis of negative opinions on CME effectiveness and (b) a summary of the educational characteristics shared by the eight "success" stories.

The eight papers—from *J Med Educ, Ann Int Med, Pediatrics,* and *Can Med Assn J*—offer valuable models for both CME program design and evaluation procedures.

Physicians Improve Performance is available to all interested at $7.00 per copy, postpaid (50% discount to members of the Illinois State Medical Society); payment is requested with order. The Handbook can be ordered from: Illinois Council on Continuing Medical Education, 55 E Monroe St, Suite 3510, Chicago, Illinois 60603.

Special

Health Care in Tanzania, East Africa

John E Thompson, MD, Nekoosa, Wisconsin

THE LARGEST proportion of the 16,000,000 people of Tanzania is made up of over 120 tribes of Bantu origin, predominantly agricultural people who migrated into East Africa 2000 years ago. A smaller portion is made of people of Nilotic and Hamitic origins, the best known of which are the nomadic pastoral Maasai, and the more recently arrived Arabic, Indian, and European immigrants.

An accurate precolonial history is difficult to determine because none of the native tribes traditionally used a written language.[1] In 1884, chiefly through commercial conquest on the coast and political-military conquest in the interior, the region of Tanganyika became a German protectorate; after the hostilities of World War I, Britain acquired Tanganyika as a mandate under the League of Nations.

The independent African Republic of Tanganyika was formed in December 1963; the Republic of Tanzania was formed on April 26, 1964 by the union of Tanganyika and Zanzibar. A young schoolteacher, Julius Nyerere, and his followers led the campaign for Independence and later founded a one-party socialist democracy with Nyerere as president. Criticism of this system has been voiced, but there is little room for bickering in a struggling society of widespread poverty, ignorance, and disease; nonetheless, Nyerere enjoys immense popular support.

Tanzania's foreign policy is based on an ideal of friendship with all nations (or nonalignment), upon the fight against colonialism, apartheid and other racial discrimination, and upon the search for African freedom and independence. The social plans of Nyerere's party include: (1) grade school education for all children, (2) literacy programs for all adults, (3) social equality for all races, (4) the establishment of "Ujamaa," or collective, cooperative villages, (5) land reform and agricultural extension, (6) basic health services for all people, and (7) national self-reliance as soon as possible.

Healthcare Delivery Structure

On the health front, the emphasis is on preventive medicine and the development of small rural health centers, which they consider to be the most cost-effective means of spending their meager healthcare resources. Their policy towards hospitals is to emphasize a system of small district hospitals, of about 40 beds, which are the first referral stage, and also oversee the peripheral rural health center dispensaries.

Rural Medical Aide (RMA)
Maternal and Child Health Aide (MCHA)

The government has planned a dispensary every ten kilometers that is staffed by one Rural Medical Aide (RMA), one Maternal and Child Health Aide (MCHA) and one Dresser. The RMA graduates after eight primary grades and three years of medical training; or after secondary education (high school) and two years of medical training. He dispenses simple drugs such as chloroquine, phenobarbital, penicillin, sulfa, aspirin, vitamins, etc, and does simple surgery, fracture care, and treats medical illnesses. The MCHA has a primary education (eighth grade) and then receives two years of midwife training. Her role is in prenatal care and deliveries at the dispensary. She also does pediatric exams, checks nutrition, and administers immunizations. The "Dresser" has an eighth grade education, is trained at the dispensary by the RMA, and cares for minor wounds, applies dressings, and administers injections.

Medical Assistants (MA)

After three years of experience in the Rural Dispensary, the RMA can apply for graduate training at Bumbuli Hospital Medical Assistants Training Center (MATC). It also is possible for persons with

[1]Recently Feierman of the University of Wisconsin and others have published anthropological research based on the historical oral traditions handed down by the elders of various tribal units in Tanzania. (Feierman S: *Shambaa Kingdom: A History*. University of Wisconsin Press, 1974)

Doctor Thompson, whose son and daughter-in-law were medical teachers in Tanzania, is deeply involved in helping East Africa's medical needs. Accompanying this article is a plea to Wisconsin physicians to provide medical textbooks so desperately needed by this troubled country. Doctor Thompson is a family physician who devotes much of his time to organized medicine as a preceptor to Physician Assistant programs, past president of the Wood County Medical Society, delegate to the State Medical Society, and a member of the Society's Physicians Alliance Commission.

Reprint requests to: John E Thompson, MD, 315 First St, Nekoosa, Wis 54457 (phone: 715/886-3175). Copyright 1980 by the State Medical Society of Wisconsin.

a secondary school education to apply directly to one of several other MA schools where a more extensive three-year program is necessary before they can obtain a Medical Assistant degree. The traditional society is male-dominated, and at Bumbuli there are no women in the classes; but the government is actively attempting to eliminate sexual discrimination in its institutions, and there is a growing number of women in the classes of the other MATCs.

At Bumbuli there were 500 applicants for the 1979 class of 40 openings; and after two years of classroom instruction and hospital experience, they will graduate as Medical Assistants. Their assignments will be at Rural Health Centers, which may occasionally contain up to 40 beds for short-term stays of up to seven days. Their duties include deliveries, more complicated surgery and wound care, administration of intravenous fluids for diseases such as cholera and other causes of dehydration, and use of a more extensive formulary—all without a doctor at the hospital.

Assistant Medical Officer (AMO)

The MA can advance to AMO after one and one-half years of further classroom and hospital training. This classification is a temporary stopgap because of the country's lack of medical school graduates. The AMO will work at a district hospital such as the one in Lushoto, a 250-bed hospital. He functions like a medical school graduate, performs major abdominal surgery, and treats major medical illnesses.

Medical Doctor (MD)

The MA, AMO, or a university graduate can apply to the university medical school at Dar-Es-Salaam, the capital city. The hospital (Muhimbili) has 1200 beds and is covered by most specialties. Each class in the four-year program has about 60 students.[2]

Resources

Tanzania is among the poorest nations in the world, with most of its population at subsistence farming levels with a per capita annual income of $100 or less. Also, there is a notable lack of exploitable mineral resources or other sources of foreign exchange. In addition, Tanzanian priorities for African unity recently necessitated the costly war against the dictator, Idi Amin of Uganda, even though its resources were desperately needed in the country's social programs.

Because of the lack of trained personnel in the technical fields such as education, agriculture, engineering, medicine, etc, the government has contracts with several international aid and development organizations. The outcome of the manpower and financial constraints in the health field is that 40-plus percent of the health services in Tanzania are provided by nongovernment international voluntary agencies. Most of these services are supplied by church mission societies, but there are a number of physicians, dentists, nurses, and health educators whom the government is recruiting from secular development agencies, including CUSO (Canadian University Services Overseas). One such project using CUSO doctors is the Medical Assistant Training Center at Bumbuli Hospital.

Bumbuli Hospital

This 200-bed hospital, grade school, and mission church complex in northeast Tanzania was started by German Lutherans in 1891. Because of endemic diseases in the lowlands, the life expectancy of the early missionaries was numbered in months. Therefore, Bumbuli Hospital was placed 5000 feet up in the Usambara Mountains.

The first Medical Assistants School in East Africa was started here in 1951. It became a state school in 1964, after Tanzania's independence was gained, but the hospital itself continues as part of the Tanzanian Lutheran Church.

The doctor-patient ratio in Tanzania still remains at 1:20,000, but in the Bumbuli Hospital area the ratio is 1:80,000. The present hospital and teaching staff includes: Dr Ernst Jacobson, Danish missionary doctor who teaches surgery and obstetrics; Dr Susan Schmitt Thompson,[3] communicable diseases and pediatrics; Dr John M Thompson,[3] general medicine and physical diagnosis; and Doctor Mtunguja (Assistant Medical Officer), pharmacy preventive medicine, and hygiene.

Health Problems at Bumbuli Hospital

Of Africa's total population of almost 400 million, about 25% are under seven years of age and 44% are under 15 years, yet in some countries up to 80% of all deaths are of children under the age of five. In a typical African country the pediatric morbidity rate is 50 times higher than in the most affluent countries.[4] There seems to be an interaction

[2]In the 1960s the only medical school in East Africa was Makerere at the University of Uganda. Tanzania started its school in the 1970s after the rise of Ugandan dictator, Idi Amin, which led to the academic disintegration of Makerere. *(Tanzania Information Guide.* Canadian University Service Overseas [CUSO], Ottawa, Canada, 1975, pp 1-14)

[3]Doctors Susan Schmitt Thompson and John Michael Thompson are wife and husband who are graduates of the University of Wisconsin Medical School, Class of 1975. They served their internships at Charleston Medical Center, Charleston, West Virginia. Both graduated from the School of Tropical Medicine—Liverpool, England, in November 1977. They were employed by CUSO (Canadian University Service Overseas) as teachers in the Medical Assistant School, Bumbuli Hospital, Tanzania, East Africa. They have since returned to the Charleston Area Medical Center in Charleston, West Virginia where they are completing Family Practice residencies. Doctor John Michael Thompson is the son of the author, Dr John E. Thompson.

[4]There is a 160:1000 mortality rate in the first year and a 250:1000 mortality rate in the first five years of life. (Malnutrition. *African Health* 1:17-20 [No. 7], 1979)

between the widespread malnutrition and infections and the outcome of mild infections is greatly influenced by the nutritional status of the child. Measles, for instance, often becomes a devastating illness; death from diarrhea, meningitis, and pneumonia is common. Kwashiorkor (protein lack), marasmus (deficient calories and protein lack), anemias, goiter, and xerophthalmia are common manifestations of malnutrition. The basic diet is corn flour, rice, greens, and bananas for carbohydrates; and protein is chiefly derived from beans. Limited, but available, for the affluent society is protein from meat, poultry, and dairy products.

Tuberculosis is the number one communicable disease problem; it is usually far advanced, often extrapulmonary, and often fatal. Malaria is endemic in the country; and it is a special problem during pregnancy for immunity seems to be lost and results in many abortions, stillbirths, and low birth weight babies. Anemias in pregnancy are common and severe, often with hemoglobins of 3 to 5 grams, due to iron, folate, and protein deficiencies as well as malarial hemolysis.

Unusual obstetrical problems are vaginal stenosis from tribal female circumcision and starvation diets practiced by some tribes because many women have a small pelvis and a small baby is needed for a vaginal delivery. Common in patients are cholera, typhoid, polio, trachoma, pneumonia, osteomyelitis, meningitis, whooping cough, leprosy, rabies, tetanus, and venereal diseases.

An unusual infection is pyomyositis which is often so extensive as to involve an entire extremity and requiring extensive fasciotomies. Common parasites are hookworm, ascaris, scabies, lice, schistosomes, amoebae (with many liver abscesses), and tunga fleas. The latter is a subcutaneous burrowing flea that causes foot abscesses and occasionally tetanus. Peptic ulcers are commonly seen at Bumbuli Hospital. The black male is predominantly blood type O and is under much mental stress in his role as family head and provider. Also, the high incidence may be related to the high serotonin intake of the banana diet.

Cirrhosis is common and often due to chronic ingestion of toxins from contaminated grains, and hepatoma is a frequent neoplasm. Coronary heart disease, cholelithiasis, and appendicitis are rare diseases. Hypertension usually responds to medical therapy. Diabetes is difficult to manage because of the high carbohydrate diet. Therapeutic goals are to control symptoms and to prevent acidosis through a single daily injection of intermediate type of insulin.

Conclusion

A brief history of a developing country in Africa, the health and social problems encountered, and the medical education system developed with the resources available has been presented. In this struggling democracy medical care is slowly improving and advancing, but the country has been unable to provide adequate care because of the lack of resources. Also, a large family is the goal of all marriages, for the elderly are respected and cared for by their children and grandchildren. Population control can possibly be obtained through the reduction of infant and child mortality; birth control will then be acceptable, and the social need for multiple pregnancies and large families can be eliminated. Without controlling the growth rate of the population, it becomes increasingly difficult to expand the health facilities to meet and keep up with the needs. It is imperative that the established affluent nations of the world provide all possible help to the developing nations in Africa. ■

Medical books needed for East Africa

East Africa needs medical text and reference books, but because of the economic crisis and problems of foreign exchange it has been difficult to purchase them. The newest of the young African democracies, Tanzania, is on the brink of bankruptcy after expending its resources fighting the dictator, Idi Amin of Uganda (recently ousted); and its social programs are in desperate need of financial help.

Textbooks are obsolete and few in number in a teaching hospital like Bumbuli. Few medical libraries are found in East Africa, although a fairly complete one is at the University in Dar-Es-Salaam, but in the smaller hospitals and dispensaries reference books are almost nonexistent. The monthly salary for the MA is $125 and the MD is $200, consequently it is difficult for them to purchase books.

—JOHN E THOMPSON, MD

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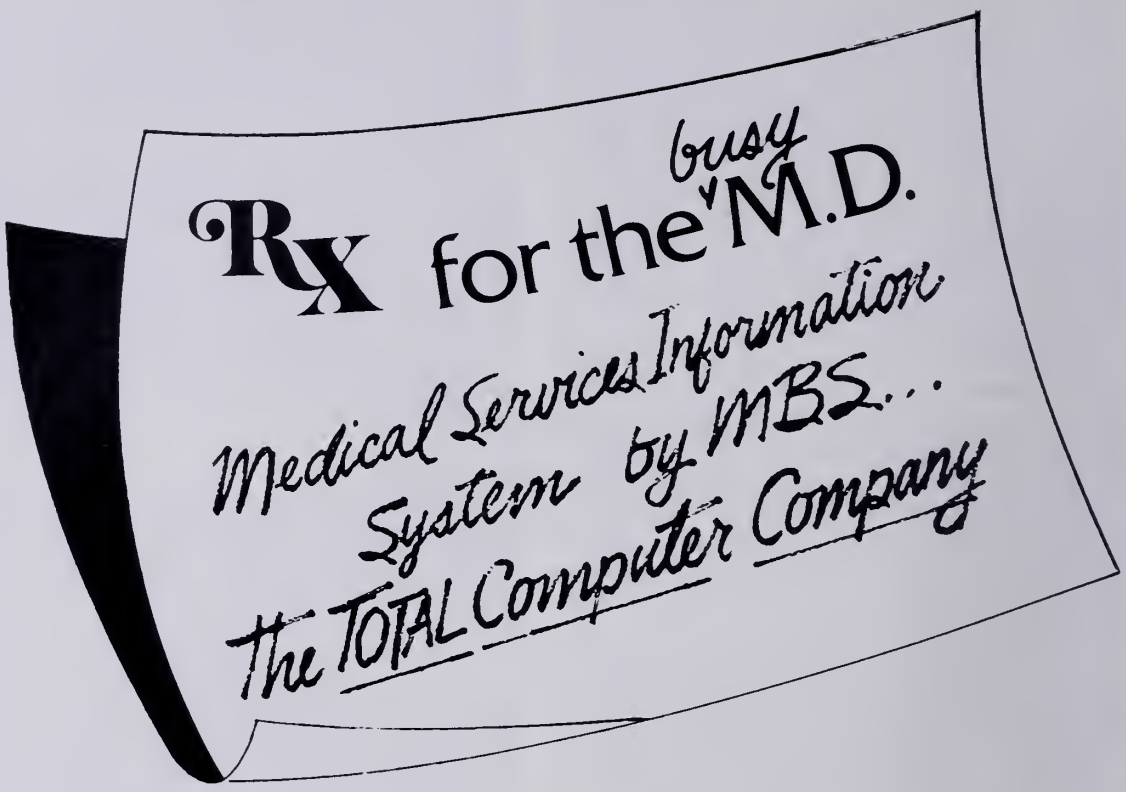
The State Medical Society's Council has accepted the proposal of Doctor Thompson that the Society building in Madison be made available as a collection station only (no financial involvement) for donations to East African medical facilities and personnel. Anyone wishing to contribute or learn more about the project should contact Doctor Thompson.



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Special

The closing of a Physician's Assistant Program

Robert A Payne, RN, PA; Dean A Stelton, PAC; Richard D Sautter, MD and **Thomas F Nikolai, MD**
Marshfield, Wisconsin

In 1972 the Marshfield Medical Foundation, Marshfield, Wisconsin initiated a Primary Care Physician's Assistant Training Program. This program was initiated because of the results obtained in a physician survey indicating a need for well-qualified, trained Physician's Assistants. This decision was also based on the fact that the Marshfield Clinic had approximately eight years of experience with an informal on-the-job training type program for Physician's Assistants. It was the intention of the program to train Physician's Assistants who could aid in the delivery of primary care in the small rural communities of Wisconsin. Since the program's inception it has gained and maintained accreditation by the American Medical Association's Council on Higher Education as well as the United States Office of Education. The program was and has remained a compact, concentrated 24-month program. The pro-

Mr Payne, formerly Associate Director of the Marshfield Medical Foundation, is currently Executive Director of the Honolulu Medical Group, Honolulu, Hawaii; Mr Stelton is Physician's Assistant Program Director, and Doctor Sautter is Executive Director, Marshfield Medical Foundation, Inc, Marshfield, Wisconsin. Doctor Nikolai is Medical Director, Physician's Assistant Program, Marshfield Clinic, Marshfield, Wisconsin. Reprint requests to: Marshfield Medical Foundation, Inc., 510 North St Joseph Ave, Marshfield, Wis 54449. (Phone: 715/387-5511) Copyright 1980 by the State Medical Society of Wisconsin.

NEWS YOU CAN USE

PRIOR AUTHORIZATION REQUIREMENTS FOR STERILIZATIONS UNDER T-19 AMENDED. The Department of Health and Social Services recently sent a Medical Assistance Provider Bulletin to all participating physicians clarifying several Medicaid (Title 19) policies contained in the recently enacted Medicaid SuperRule. In that bulletin DHSS amended its policy in regard to prior authorizations for sterilizations. Prior authorizations will be required for all sterilization procedures performed by physicians after June 1, 1980 for purposes of confirming age and eligibility status only of the recipient prior to surgery. The review will *not include a review of medical necessity.*

INTERNATIONAL HEALTH ALUMNI PROJECT SEEKS SUPPORT. The Office of International Health Affairs at the UW Center for Health Sciences reports that as a consequence of severe financial constraints in the medical school budget, International Health activities will be curtailed. The Office now is launching a special "International Health Alumni Project" in an effort to continue to provide overseas learning experiences for UW medical students and overseas volunteer service opportunities for practicing Wisconsin physicians who are considering work experiences in developing countries by identifying opportunities and providing appropriate orientation material; providing guidance and support to UW medical students interested in overseas electives; and presenting programs related to International Health for premedical, medical students, and physicians. The project is seeking financial support from UW medical school alumni. For more information, or to make a contribution, contact Ned Wallace, MD, Director, Office of International Health Affairs, 610 Walnut St, Madison, Wis 53706. ■

gram operated year-round with no traditional educational vacations.

The first class entered the program in June 1972 and every year thereafter a class was begun. With the 24-month curriculum, this maintained one class in the didactic phase of the program with the second-year class in the clinical practicum. The didactic portion of the curriculum was taught at the University of Wisconsin—Marshfield/Wood County Campus and consisted of basic science courses taught by the University faculty and the clinical sciences taught by the staff and members of the Marshfield Medical Foundation, Marshfield Clinic, St Joseph's Hospital, and selected community health agencies. Clinical sciences were taught by body system and consisted of 14 such modules. The last 13 months were spent in 14 different clinical rotations in the Marshfield Clinic and St Joseph's Hospital as well as local health facilities. The final two months of the course were spent in a preceptorship, generally, in North Central Wisconsin in small rural communities with either a private practitioner, partnership, or small group practice.

Table 1—Number of graduates in Primary Care Physician's Assistant Training Program, Marshfield Medical Foundation: 1974-1979

Year of graduation	*Number graduated*
1974	10
1975	11
1976	16
1977	18
1978	18
1979	14
TOTAL	87

Table 2—Location of graduate

Wisconsin	61
Michigan	2
Minnesota	3
Colorado	3
Alabama	1
Arizona	1
South Dakota	1
Washington	1
Oregon	1
Maine	1
Illinois	2
New Hampshire	1
Alaska	1
North Carolina	1
New Mexico	1
North Dakota	1
Not working as a PA	5
TOTAL	87

The preceptorship mechanism worked well in placing the Physician's Assistant in areas with health manpower need and resulted in a 72% rate of ongoing employment for the Physician's Assistants and the Wisconsin Board Examination as well, has been very gratifying. The graduates have placed in the top 10% on the National Boards of the current 57 Physician's Assistant Program graduates in the United States. It has been the philosophy of the Marshfield Medical Foundation to continually assess the need and demand for Physician's Assistants. In mid-May 1979, that assessment brought us to the decision to discontinue this program. We graduated 14 students in July 1979 and will be graduating another 10 students in July 1980. At that time, the program will be terminated.

The reasons for terminating the PA training program were dependent upon the following significant factors:

(1) A greater retention of physicians in the State of Wisconsin over the last five years.
(2) The number of physicians graduated by the two medical schools in Wisconsin has doubled since 1967.
(3) The emergence of two Nurse Practitioner Programs and another Physician's Assistant Program in the state has more than doubled the production of physician extenders in the last four years.
(4) The state population growth in the last five years has been less than 1.5% while at the same time the physician growth has been 11%.
(5) There has been a continual increase in the number of out-of-state trained Physician's Assistants gaining employment in the state in the last four years.
(6) There have been more physicians moving into the northern part of the state, supplanting potential Physician's Assistant job opportunities in that area.

Tables 1 and 2 reflect the year of graduation and the number of graduates in each of those years, as well as the in-state and out-of-state locations of the graduates and the type of healthcare delivery in which they are currently engaged. The community size in which our graduates are employed is also reflected in these tables. All of these are significant factors of which the Marshfield Medical Foundation Physician's Assistant Program staff is extremely proud. The decision to open this program and pioneer in the Physician's Assistant effort in Wisconsin was a major one on the part of the Marshfield Medical Foundation. However, the most difficult decision the Foundation has had to make concerning the Physician's Assistant concept was the decision to terminate this program with the completion of the class in 1980. ■

on-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® CIV

meprobamate and ethoheptazine citrate with aspirin) Wyeth

ic—Abbreviated Summary

NCTIONS: Based on a review of this drug by the Academy of Sciences—National Research and/or other information. FDA has classified abons as follows

Poly effective for the treatment of pain accompy tension and or anxiety in patients with musetal disease or tension headache

assification of the less-than-effective indicaquires further investigation

The ctiveness of Equagesic in long-term use, i e an four months, has not been assessed by thc clinical studies The physician should peeassess usefulness of the drug for the indiatient

NTRAINDICATIONS: Equagesic should not be given to with a history of sensitivity or severe intolerance eprobamate or ethoheptazine citrate

RNINGS: Careful supervision of dose and amounts pre patients is advised, especially with those patients propensity for taking excessive quantities of drugs. and prolonged use in susceptible persons, e g , formerr addicts, and other severe psychoneurotn reported to result in dependence on or habit e drug Where excessive dosage has continued x months, dosage should be reduced gradually abruptly stopped since withdrawal of a "crutch" rate withdrawal reaction of greater proportions which the drug was originally prescribed Abrupt ce of doses in excess of the recommended dose in some cases in the occurrence of epileptiform

should be taken to warn patients taking meprotolerance to alcohol may be lowered with reing of reaction time and impairment of judgement ation

E PREGNANCY AND LACTATION: An inct of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, Pa 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed

WHY NOT WYGESIC® ℠

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of those patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as local or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphen, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other su[illegible] tive measures should be used as indicated. C[illegible] lavage may be helpful. Activated charcoal ca[illegible] sorb a significant amount of ingested propoxy[illegible] Dialysis is of little value in poisoning by pro[illegible] phene alone. Acetaminophen is rapidly abs[illegible] and efforts to remove the drug from the body [illegible] not be delayed. Copious gastric lavage and or[illegible] tion of emesis may be indicated. Activated ch[illegible] is probably ineffective unless administered [illegible] immediately after acetaminophen ingestion. [illegible] forced diuresis nor hemodialysis appears to [illegible] fective in removing acetaminophen. Since ac[illegible] nophen in overdose may have an antidiuretic [illegible] and may produce renal damage, administra[illegible] fluids should be carefully monitored to avoid [illegible] load. It has been reported that mercaptamine [illegible] teamine) or other thiol compounds may protect [illegible] liver damage if given soon after overdosage [illegible] hours). N-acetylcysteine is under investigatio[illegible] less toxic alternative to mercaptamine, whic[illegible] cause anorexia, nausea, vomiting, and drow[illegible] Appropriate literature should be consulted for [illegible] information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxic[illegible] be delayed up to one week. Acetaminophen [illegible] levels and half-life may be useful in assess[illegible] likelihood of hepatotoxicity. Serial hepatic a[illegible] determinations are also recommended.

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Scientific Medicine

REFER TO —Chesney RW, Friedman AL, Segar WE: The hemolytic-uremic syndrome in Wisconsin: Experience in 22 cases. *Wisconsin Med J* 79:21-23 (July) 1980

KEY WORDS—Hemolytic-uremic syndrome (HUS), childhood diseases

The hemolytic-uremic syndrome in Wisconsin: Experience in 22 cases

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Madison, Wisconsin

• *The hemolytic-uremic syndrome (HUS) is characterized by several days of bloody diarrhea, microangiopathic hemolytic anemia, thrombocytopenia, and renal impairment with azotemia. Twenty-two children between one month and 16 years have been diagnosed with the HUS, 19 since 1975. Nineteen (86%) of the children have survived and in only one is there evidence of chronic renal involvement.*

Acute renal failure, thrombocytopenia and a microangiopathic hemolytic anemia are characteristic of the hemolytic-uremic syndrome (HUS). This syndrome is of unknown etiology and typically affects preschool children.[1,2] The prodrome of bloody diarrhea is probably an important part of the disease process and may be confused with ulcerative colitis, appendicitis, or intussusception.[3] The therapy of this disorder is supportive including transfusi ons, antihypertensive medications, and, in most cases, peritoneal dialysis. We herein report the clinical features, hospital course, and outcome of 22 children admitted to the University of Wisconsin Hospitals during the past 14 years.

From the Pediatric Renal Disease Laboratory, University of Wisconsin-Madison Clinical Sciences Center, Madison, Wisconsin. Reprint requests to: Russell W Chesney, MD, UW-Madison Clinical Sciences Center, Dept of Pediatrics, 600 Highland Ave, Madison, Wis 53792. (Phone: 608/263-8558) Copyright 1980 by the State Medical Society of Wisconsin.

PATIENTS. Each patient had the diagnosis of the HUS made on the basis of anemia with morphologic evidence of intravascular hemolysis, thrombocytopenia, azotemia, hematuria, proteinuria, and the presence of either granular or cellular casts in the urine. Nineteen of the 22 patients have been admitted to the hospital since July 1975, indicating that approximately five patients appear each year with this diagnosis. Patient records were evaluated for this study, and patients included in the study exhibited all criteria for this disorder.

RESULTS. The age range of patients was five weeks to 16 years with a mean age of 4-2/12 years. Nine boys (41%) and 13 girls (59%) had the disease. A gastrointestinal prodrome was found in 22 of 23 patients (96%). The gastrointestinal features included diarrhea, vomiting, and bloody stools in all. A laparotomy for suspected appendicitis was performed in two, a laparotomy for a cecal filling mass in one, a suspicion of ulcerative colitis or toxic megacolon in three, and abdominal tenderness was present in nearly all. One patient had peritoneal signs with colonic necrosis and perforation. The length of this prodrome varied from 4 to 45 days. Many patients had hepatomegaly, and an elevated SGOT occurred in all of 15 patients examined (mean value 173 IU/L); and the SGPT was elevated in eight of eight examined (mean value 139 IU/L) (Fig 1).

All 22 patients were anemic: the mean hemoglobin was 6.7 gm/dl and the mean hematocrit was 17%. Thrombocytopenia was also universal with a mean platelet count of 51,000 ± 30,000 (SD) per mm^3. Twenty-one of 22 patients had leukocytosis with a mean white blood cell count of 23,300 per mm^3. The high leukocyte count returned to normal within a few days in all patients. A red blood cell smear showed evidence of intravascular hemolysis with schizocytosis, burr cells, and fragmented cells in every patient. The consistently elevated reticulocyte count, elevated lactic dehydrogenase levels (mean 1750 IU/L), and pallor provided additional evidence of acute hemolysis. In addition, the serum uric acid, was elevated (17.6 ± 3.4 mg/dl) providing evidence of rapid turnover of young erythrocytes. Clotting studies (PT, PTT and fibrinogen) were normal whenever sought.

Renal failure was manifest by oliguria in 19 of 22 patients, by azotemia in all (mean blood urea nitrogen 121 ± 47 mg/dl), by an elevated serum creatinine (mean 6.9 mg/dl), and an active urinary sediment. Urine always disclosed marked proteinuria, hematuria, and cylinduria in each patient. Twelve patients had either anuria lasting more than 24 hours or oliguria severe enough to require peritoneal dialysis. Several patients required more than one dialysis. Besides anuria or oliguria with obtundation related to uremic symptoms, dialysis was also required for hyperkalemia, congestive heart failure, and pulmonary edema, as well as anuria or oliguria with mental obtundation. Twenty of the patients were hypertensive with a mean blood pressure of 132/92 mm Hg.

Possible etiologic factors were identified in a few patients. Serologic evidence for a Coxsackie B3 infection with rising titers was found in four patients, a stool isolation for this virus was found in two of these patients. Two patients had their illness within three weeks of a varicella infection. Two sisters had the disease suggesting that they developed a genetic form of the disease.[4] In one of these patients the disease followed a rubella vaccination by a few days. Another patient had 32 days of a diarrheal illness before pallor and oliguria were noted. His twin brother experienced a similar diarrheal illness that lasted only one week, but he had no evidence of hematuria, proteinuria, or anemia.

Virtually all patients were irritable and seizures occurred in five. Another patient developed ataxia and dysarthria lasting several months. Echocardiographic evidence of cardiac hypertrophy was found in two patients.[5]

Packed erythrocyte transfusions were given to children whose hemoglobin was less than 6.0 gm/dl, and fluid and potassium restrictions were routinely ordered for patients with marked oliguria. Several patients were dehydrated on admission, probably from prolonged diarrhea, and required intravenous fluid therapy. However, azotemia persisted despite adequate hydration in each. Antihypertensive therapy, particularly intravenous diazoxide, hydralazine, and propranolol, was frequently required. Two patients, seen prior to 1975, were treated with heparin to prolong clotting factors, but this practice has been abandoned.

Nineteen of the 22 patients survived. One patient died after four months of illness complicated by severe necrotizing bowel disease and peritonitis. This patient also required chronic hemodialysis. The sisters mentioned above died of anuria at ages 15 and 28 months. Of the 19 survivors, 17 have normal

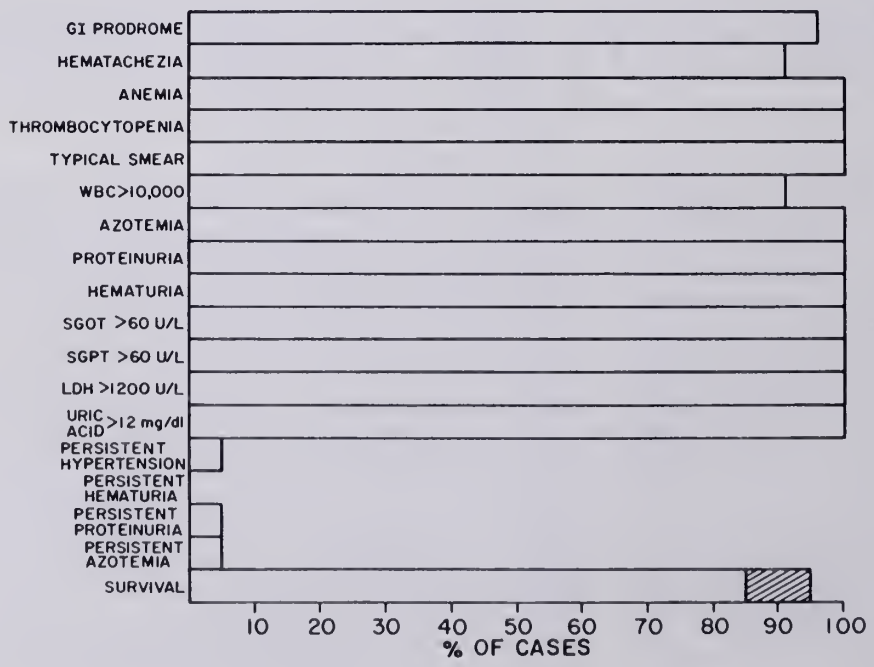

Figure 1—*The clinical features in the 22 patients expressed as a percentage of cases. The lower portion of the figure shows the survival percentage (86%). The cross-hatched area indicates the two patients with the familial form of the disease where the mortality rate is approximately 75%.*

blood urea nitrogen (16 ± 3 mg/dl) and creatinine (0.6 ± 0.3 mg/dl) levels, a normal blood pressure, and at their most recent evaluations have no evidence of hematuria or proteinuria. A single patient has a serum creatinine level of 1.4 mg/dl, persistent hypertension, and 650 mg protein excretion daily. The remaining two patients have not had a long enough recovery period to be evaluated.

DISCUSSION. This report describes the characteristics of the HUS in 22 children treated at the University of Wisconsin Hospitals since 1963. In this series, virtually all the patients had the characteristic "prodromal" gastrointestinal symptoms which are probably an integral part of the syndrome.[2] They had the typical features of microangiopathic hemolytic anemia with extremely low hematocrit levels, thrombocytopenia and oliguria with proteinuria and hematuria. Hypertension was an almost universal finding and was often difficult to treat.

In this series heparin therapy was used in only two patients, one of whom died of nonremitting disease. An overall survival rate of 90% was achieved through the use of conservative therapy for acute renal failure, including fluid restriction, blood transfusions, appropriate treatment of hypertension, and peritoneal dialysis. All of the 10 mildly affected patients, who did not require dialysis, survived as did 9 of the 12 patients requiring dialysis. Two of the deaths were in sisters who probably had the genetic form of the disease, in which a mortality rate of approximately 75% is expected.[3] Accordingly, if these two patients are excluded, the overall mortality rate is 1 of 20 (5%) which compares favorably with the results elsewhere.[1] It is encouraging that only one patient had evidence of persistent renal disease with hematuria, proteinuria, and hypertension. It is not clear whether any of the other patients will subsequently develop hypertension or proteinuria since 19 of them have been treated since 1975.

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Abstracts

Treatment of herniated lumbar disk syndrome with chymopapain

MANUCHER J JAVID, MD (University of Wisconsin Clinical Sciences Center, Madison, Wis): *JAMA* 243:2043-2048, 1980

One hundred twenty-four patients with herniated lumbar disks received intradiskal injections of chymopapain before the Food and Drug Administration's withdrawal of the drug. One year after injection, 90 patients (72.6%) experienced major improvement, 21 (16.9%) had slight improvement, and 13 (10.5%) had no improvement. Of those patients who had no previous back surgery and who were not compensation cases, 77 patients (81%) had marked improvement, 13 (13.7%) had slight improvement, and five (5.3%) had no improvement. Three- to six-year follow-ups were obtained by questionnaire. Of the 114 patients responding, overall 83 patients (72.8%) had marked improvement, and 75 (83.3%) of those with no previous surgery and who were not Worker's Compensation cases had major improvement. Since all patients met objective criteria for diskectomy, favorable results from chemonucleolysis spared most the trauma of surgery and its attendant convalescence. These results indicate that chemonucleolysis can and should be considered an advantageous alternative to surgery in appropriately selected patients. ■

Toxicity of combined therapy with carbonic anydrase inhibitors and aspirin

CHARLES J ANDERSON, MD; PAUL L KAUFMAN, MD; and RODNEY J STURM, MD, University of Wisconsin Center for Health Sciences, Madison, Wis: *Am J Ophthal* 86 (No 4): (Oct) 1978

A 67-year-old woman and a 75-year-old woman taking carbonic anhydrase inhibitors for therapy of glaucoma and high doses of aspirin for therapy of arthritis developed severe acid-base imbalance and salicylate intoxication. Neither patient exhibited ill effect when taking high aspirin doses without carbonic anhydrase inhibitors.

Salicylic acid has a pK' of 3, and is thus highly ionized (99.996%) at normal blood pH of 7.4. A small change in blood pH causes a large change in blood concentration of the nonionized form. Because ionizable drugs penetrate biologic membranes primarily in their nonionized form, acidemia should enhance the penetration of salicylates from blood and extracellular space into the central nervous system and other tissue. Therefore, carbonic anhydrase inhibitor induced acidemic increases the risk of developing salicylate intoxication in patients receiving high aspirin doses. In patients requiring such combined therapy, low doses of methazolamide (which cause little or no systemic acidosis), oral bicarbonate, or both, should decrease the risk of severe toxicity. ■

REFER TO—Hansotia PL, Johnson I, Bauman D, Sommers PA, and Fuchs C: Knowledge, understanding, and attitudes about epilepsy. *Wisconsin Med J* 79:24-26 (July) 1980

KEY WORDS—Epilepsy

Knowledge, understanding, and attitudes about epilepsy

Phiroze L Hansotia, MD; Irene Johnson, RN; Donna Bauman, RN; Paul A Sommers, PhD; and **Camil Fuchs, PhD,** Marshfield, Wisconsin

• *Two epilepsy survey questionnaires, one assessing knowledge and understanding and a second, assessing attitudes and awareness, were developed and administered to groups representing the general public (N=200) and clinic employees (N=200). Each questionnaire was given to 100 different respondents from each group. Comparisons were made of the findings which yielded statistically significant difference in favor of the clinic employees on a majority of the questions in both surveys. However, the significant results were secondary to generalized findings of misunderstanding, poor attitudes, and an overall lack of awareness about epilepsy. Based upon these findings, an educational conference was held to focus on current medical, legal, employment, and insurance-related issues. Pre- and post-tests were given participants with significant findings in the direction of the post-test. Although the conference was but a minor activity, it did produce a positive result that can be replicated.*

In conclusion, the most meaningful recommendations include: (1) repeat the epilepsy surveys with other populations to determine if similar effects are recorded; (2) following an analysis of survey data, develop and implement concentrated educational programs on a longitudinal basis for a meaningful and lasting effort in the fight against misunderstanding, poor attitudes, and overall lack of awareness about epilepsy.

Epilepsy affects more Americans than cancer, tuberculosis, cerebral palsy, muscular dystrophy, and multiple sclerosis combined according to the Epilepsy Foundation of America.[1] However, in the same vein "epilepsy is a condition which attracts more myths, arouses more fear and horror, and is bound up with more superstition than almost any other illness experienced by mankind."[2] A symptom often referred to as a disease, epilepsy affects an estimated two (2) million individuals (at least 1% of the population) living in the United States today according to a recent report by The Commission For The Control Of Epilepsy And Its Consequences.[3] Technically defined, epilepsy which is commonly referred to as a seizure disorder is:

> "a chronic symptom of cerebral dysfunction, characterized by recurrent attacks involving changes in the state of consciousness, sudden in onset and of brief duration."[4]

There is a belief that an individual with epilepsy faces a life of prolonged frustration and a continual uphill battle to overcome the consequences associated with this condition. Related consequences include questionable social acceptance; physical hazards if left uncontrolled; public embarrassment when seizure activity occurs in front of others; lack of self-confidence; and, incongruent perceptions of how significant others perceive the individual who displays seizure activity.[5,6,7,8]

Efforts to help the patient with seizures have basically remained in the medical treatment domain, yet the consequences faced by the patient with epilepsy more often occur in society.[9] A question of public understanding about epilepsy and attitudinal differences has long been a subject of discussion.

A good deal of the information available documents epilepsy in relation to education[10,11,12] or epilepsy as it is understood by employers, teachers, and by other persons with epilepsy.[13,14,15] However, there has been a paucity of social awareness information drawn from the general public about epilepsy with the exception of the longitudinal public attitude opinion surveys conducted by Caveness et al over the years.[16] More recent studies of epilepsy have been epidemiologically based[17] rather than oriented towards attitude and understanding. However, the authors stress that by understanding how society in general perceives epileptic individuals, a concerted program of public awareness, informa-

Doctor Hansotia is a Neurologist; Ms Johnson, a Patient Educator; Ms Bauman, a Liaison Nurse; and Doctor Sommers is Director, Liaison Education Affairs, Comprehensive Child Care Center, all of the Marshfield Clinic, Marshfield, Wisconsin. Doctor Fuchs is from the Department of Statistics, University of Wisconsin-Madison, Madison, Wisconsin. Publication support provided. Reprint requests to: Paul A Sommers, PhD, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449 (Phone: 715/387-5511)
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tion, and education will positively influence improved understanding of this illness.

Data provided by Caveness and associates[16] describe through trend analysis method the change in concept individuals throughout the United States have toward epilepsy as it relates to the intellectual, social, and economic spheres of our society. The present study attempts to assess and compare general public and clinic employee knowledge, understanding, awareness, and attitude levels associated with epilepsy.

SAMPLE SELECTION. A sample of 100 members of the general public and 100 clinic employees was asked knowledge and understanding questions in an open-ended response format. Attitude and awareness information was surveyed from another sample (general public N=100, clinic employees N=100) by asking questions posed in an objectively based multiple choice manner. Adults (males and females chronologically 18 years or older) were invited to participate. Questionnaires were distributed to general public samples of adults who accompanied patients to the Marshfield Clinic who were not being seen for epilepsy or treated in the Department of Neurosciences. A stable outpatient catchment area complete with increasing referrals has helped to assume randomness in the selection of study respondents.

Clinic employees were invited to participate from a nonphysician population of approximately 1000 allied healthcare workers. Those accepting to participate functioned in nonclinical capacities; *ie,* receptionists, stenographers, secretaries, messengers, etc. An exclusion was made of those workers assigned to the Department of Neurosciences since it was believed that Neuroscience staff would bias the results because of their daily contact with patients who have epilepsy.

LIMITATIONS. Both surveys were subject to two limitations which should be considered when interpreting the results. First, there is a margin of error inherent in all sampling surveys. Both samples (general public and clinic employees) were selected from within the Universe of the Marshfield Clinic. Second, breakdowns in the tabulation are subject to a larger possible degree of variation than national expectancies because of the size of samples. Breakdowns based on less than 200 to 300 cases should be used with caution. No attempt was made to control the study populations for ethnic background, sex, economic status, or population density nor was it the intent to compare epilepsy to other neurological conditions or medical problems.

RESULTS. *Epilepsy Knowledge and Understanding Survey:* More than 8 out of 10 general public respondents and 6 out of 10 clinic employees did not understand that epilepsy was an involvement of the central nervous system. Similarly, a lack of understanding permeated throughout the remaining questions; *ie,* how epilepsy occurs; that it cannot be cured; its relationship to intelligence; and the main difficulties faced by a person with epilepsy in employment, education, socially, and legally.

A major focus of the study was to compare the difference in answers between the general public and clinic employee samples. Statistically significant differences in favor of the clinic employees (P–values less than .05) were noted in the questions which deal basically with the medical aspects of epilepsy: (1) what is epilepsy?, (2) how does it occur?, and (3) can it be cured? There were no statistically significant differences between the two groups on the remaining questions which deal with the difficulties faced by the person with epilepsy.

Epilepsy Awareness and Attitude Survey: Since there is a dearth of available attitude and awareness information on epilepsy, a specific focus was placed on obtaining a current review. For example, 66 percent of the general public and 93 percent of clinic employees agreed that an epileptic seizure is a symptom of a brain irritation. A comparison of the difference in answers between the general public and clinic employees for this question was found to be significant in favor of the clinic employees (P–value = .001).

Each question on the attitude and awareness survey was analyzed in this manner. Questions 1 through 17 dealt with awareness aspects while questions 18-20 dealt with attitudes. Most findings indicated that clinic employees were more accepting of the person with epilepsy. A major concern is reflected throughout the data. Neither group, the general public nor clinic employees, demonstrated very positive attitudes toward people with epilepsy. Moreover, the more positive attitudes of the clinic employees are not associated with an acceptable level of awareness. Indeed, without variation relatively few study respondents indicated appropriate knowledge, understanding, or awareness about epilepsy. This finding led to the development of a statewide educational conference on epilepsy to promote increased understanding and awareness.†

Impact of Statewide Educational Conference On Epilepsy: The main purpose of the educational conference was to share with professionals and the general public the most current information available on epilepsy with a focus on medical, legal, and employment implications. Approximately 125 per-

† Further details including tables illustrating survey questions and statistical analysis are available on request to author.

sons from throughout Wisconsin attended the conference. Pre- and post-tests were administered with 57 persons completing both. Fifteen test questions addressed current medical, legal, insurance, and employment issues.

Analysis of the difference in scores for the 57 taking both the pre- and post-tests indicate a significant difference. This finding is positive in the direction of the post-test and can be interpreted to mean that the education provided during the conference promoted an increase in understanding and awareness of the subject matter ($N=57$, $\overline{X} = -2.175$, $S^2 = 2.38$, t statistic $= -6.890$, and P−value $= .001$). Care must be extended when interpreting these results: (a) It is quite possible that persons who benefitted most from the conference chose to answer both the pre- and post-tests while the impact on the nonrespondents was not so significant. (b) The topics covered in the conference (and on the test) were intended to increase the knowledge and understanding. How this better understanding is translated in change in attitude is still an open question. But even if the conference had an impact only on part of the audience and only on some aspects of the problem, the result is meaningful since we know positive gains can be made when appropriate educational efforts are extended.

DISCUSSION. Epilepsy has often been classified in the literature to be misunderstood by the general public, school teachers, and allied health professionals. Concomitantly, a review of attitudes has indicated that persons with epilepsy are feared by their fellow workers, peers and are generally not perceived as acceptable for reasonable employment. These impressions drawn from the reviewed literature cited in the reference section were confirmed and further personified by this study.

Acceptable knowledge and understanding of epilepsy was found to vary over 60% among general public and clinic employee responses dealing with fairly general aspects *(ie,* "Does epilepsy always affect intelligence?" to "What are the main difficulties epileptics face legally?"). Most noteworthy of all study findings was the consistently poor level of understanding among and between groups on all survey questions. Although statistically significant results were noted on a majority of questions in favor of clinic employees (as expected), the fact remains that neither group performed acceptably by any standard.

A significant void of comparable research in the literature makes it difficult to compare and discuss the attitude and awareness data against. In 1974 Caveness and associates referenced general trends indicating a stable improvement of public attitudes over the past 25 years. Current study results found relatively poor attitudes and a generalized lack of awareness throughout the survey. This survey should be repeated in different locations to determine the consistency of findings longitudinally and by different population samples.

The lack of knowledge and understanding coupled with poor attitudes and awareness led to an educational program aimed at promoting understanding and improved attitudes. The educational program stressed current information on medical, legal, insurance, and employment issues and on a small scale it proved quite successful. Based upon all of the activities involved with this study, the most meaningful recommendations would be to repeat the epilepsy surveys with a variety of populations followed by the implementation of educational programs for the same populations (short- and long-term) to focus on areas of misunderstanding, poor attitudes, and lack of awareness. Only concentrated educational efforts longitudinally applied will have a meaningful and lasting impact in the fight against epilepsy.

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ONE OF A SERIES
COORDINATED BY

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TOXEMIA IN PREGNANCY

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Milwaukee, Wisconsin

TOXEMIA, although a disease known from antiquity, is still in 1980 a disease with an obscured etiology and pathogenesis, and one which can still surprise us with unusual presenting symptoms.

There has been a dramatic decline in maternal mortality from toxemia of pregnancy. In 1940 there were 52.2 maternal deaths per 100,000 live births. In Wisconsin this figure has fallen to 0.5 per 100,000 live births during the last ten years. In a recent study involving a large number of eclamptics, 90% of these women were found to have inadequate or no prenatal care. In addition, 43% had their first seizure after being admitted to the hospital, because the signs and symptoms of impending convulsions were so easily missed.[1] Therefore, it seems that a combined effort by patients and physicians can prevent eclampsia. As physicians, our responsibility includes knowing who is at risk, what the signs and symptoms of toxemia are, and who to treat, so that it is not too little, too late, or too inappropriate.

Who is at greatest risk for toxemia? This is a disease of the young primipara, but also the older multipara. Lower socioeconomic groups have a higher incidence of toxemia. This has in the past been thought to implicate nutrition as a causative factor, but the World Health Organization has stated that there is "no scientific basis for believing that deficiency or excess of any essential nutrient predisposes to preeclampsia and eclampsia." It is more likely that poor prenatal care and more childbearing at the two extremes of the reproductive years plays a role in this group. It is a disease usually seen after the 36th week of pregnancy and infrequently before 28 weeks gestation, unless a predisposing condition such as a hydatidiform mole, multiple pregnancy, diabetes, hypertensive vascular disease, or chronic renal disease is present.

Can toxemia occur in anyone else? Occasionally. We must not put aside this diagnosis in any pregnant woman, because she does not fit this stereotype.

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What are the signs and symptoms for which we should be watchful? With just a blood pressure, weight and urine protein evaluation each visit, almost all incipient preeclampsia can be found; but it is more complicated than the well known triad of hypertension, edema, or proteinuria. We cannot only use the standard definition of a diastolic blood pressure of at least 90 or a systolic pressure of 140 because the normal blood pressure is lowered in pregnancy to an average of 103 ± 11 systolic and 56 ± 10 diastolic. A rise in the diastolic pressure of 15 or a rise in systolic pressure of 30mm over baseline is significant. Nearly 25% of all eclampsia occurs with blood pressures that normally would be considered borderline and nearly half occur with blood pressures of less than 160/110.

Obesity or increased weight gain (greater than 30 lb) does not predispose to toxemia. It is the pattern of gain which is important. A weight gain of more than 2 lb in one week or 6 lb in one month must be suspect for impending preeclampsia. Eclampsia may occur in up to 20% of women without edema and in 60% with only slight or moderate findings. In addition 41% of eclamptics have not manifested proteinuria.

When a less common manifestation of preeclampsia is the presenting symptom, the diagnosis has at times been totally missed and these women mistakenly were thought to have such things as retinal detachment, nephrosis, hepatitis, cholelithiasis, pancreatitis, brain tumor, thrombocytopenia, or microangiopathic hemolytic anemia.[2]

How is this disease best treated? It varies by the severity; and despite our modern advances, delivery is still the only cure. New treatment regimens must be weighed against those with which we have had such great success; *ie,* bedrest in the lateral recumbent position, magnesium sulfate to decrease central nervous system irritability, and hydralazine for severely elevated blood pressure.

The mechanism for salt and water retention in toxemia is not well understood. However, it is known that salt restriction will not prevent toxemia.[3] Diuretics, particularly the thiazides, should never be used in toxemia. They have been proven not to

prevent toxemia or change the course of the disease. For the mother it will make worse an already compromised intravascular volume and may fatally deplete sodium and potassium stores. For the infant it decreases placental perfusion[4] and may cause hyperbilirubinemia, thrombocytopenia, and altered carbohydrate metabolism.[5]

Gant has shown that placental perfusion is decreased with toxemia[6] and these placentas frequently show massive infarction. The baby will often do better in a neonatal intensive care unit than in a compromised maternal environment.

Our goal must always be to avoid jeopardizing maternal health and deliver a live infant that has all the potential to thrive. In fact, that is the essence of all obstetrics.

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Abstracts

Postoperative occlusion after carotid endarterectomy

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Noninvasive testing (Doppler imaging and spectral analysis of carotid flow) was performed in 70 symptomatic patients who required unilateral carotid endarterectomy. Angiographic correlations were made with the noninvasive tests before surgery, and postoperatively hemodynamic changes were determined during a three-year follow-up period. Postoperative stenosis occurred in 9% (3% early and 6% late) of the patients. Clinical progression on the unoperated side (new symptoms or bruits) occurred in 15 patients. Ten of these 15 patients had significant hemodynamic progression of disease in the unoperated carotid as well. Clinically occult hemodynamic progression of disease on the unoperated side was detected by noninvasive testing in four of the cases. Neurological complications resulting from postoperative occlusion occurred in two cases. ■

Relapsing polychondritis

HAL B RIDGWAY, MD; PHIROZE L HANSOTIA, MD, and WILLIAM F SCHORR, MD, Marshfield Clinic, Marshfield, Wis: *Arch Dermat* 115:43-45, 1979

Relapsing polychondritis is an unusual disease of undetermined etiology. This disease is an inflammatory disease of cartilaginous tissue throughout the body, felt by many to represent an autoimmune phenomenon. The course of relapsing polychondritis is variable, but usually progressive with destruction, degeneration, and eventual fibrosis of cartilage, leading to disability and, occasionally, death.

The most common complaint is painful swelling and redness of the pinna of the ears. This may be either accompanied or preceded by general systemic symptoms, such as fever, headache, or malaise. Other cartilaginous structures frequently become involved in the inflammatory process, giving rise to polyarthralgias, nasal tenderness with subsequent deformity, and tracheobronchial involvement, which may lead to acute respiratory failure. Involvement of the laryngeal cartilage can produce laryngitis. Middle and inner-ear chondritis may give rise to complaints of vertigo and auditory dysfunction. The ocular manifestations most frequently described are iritis and conjunctivitis. Laboratory findings all support an acute inflammatory process, but only a biopsy specimen of involved cartilage is diagnostic for this disease.

The treatment of this intriguing disease in the past has consisted of long-term systemic steroid therapy. We describe five additional cases of relapsing polychondritis and note that dapsone provides an excellent alternative, if not preferred, treatment for this disease. (Doctor Ridgway, who was a resident at the Marshfield Clinic at the time this paper was written, is now in private practice at the East Madison Clinic in Madison.) ■

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KEY WORDS—Cesarean section, maternal mortality, birth rates

Cesarean section deliveries

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MUCH CONCERN has been expressed over the increased cesarean section rate in this country. The article in another section of this journal reports a 147% increase in the cesarean section rate over the last three decades in Wisconsin. This in spite of an apparent decrease in the number of high-risk pregnancies.

A recent report from data collected in Rhode Island[1] suggested a 26-fold increase in the death risk for women undergoing cesarean sections.

Until the early 1930s the high rates of maternal mortality after cesarean sections limited its use. However, with technical advances maternal mortality rates have dropped rapidly and a recent study from the Boston Lying-in Hospital reported no maternal deaths in 10,331 cesarean sections.[2]

More recent negative reports fail to consider that women undergoing cesarean sections often have independent risk factors that may contribute to death. Perhaps more important, the level of medical expertise and the patient population must be considered. The experience from Boston indicates that at a Level III hospital with full-time obstetric, anesthetic, medical and surgical specialists as well as facilities and equipment necessary to care for critically ill patients, the maternal mortality associated with cesarean deliveries is not different from that associated with vaginal deliveries.

What are the documentable factors affecting cesarean birth rates?

1. As already mentioned, the safety of the procedure for the mother.
2. Improved prognosis for the fetus at risk. This includes diabetes, placenta previa, selected breech cases, low birth weight, fetal heart rate abnormalities and other entities like genital herpes.
3. Increase in the proportion of care rendered by trained obstetricians.
4. A more functional approach to the management of labor as opposed to older anatomic considerations leading to more sections performed for failure to progress or cephalopelvic disproportion. It is of interest that Bottoms et al[3] reported dystocia as the largest single cause for the increased incidence of cesarean sections.
5. Previous cesarean sections.

In view of the general improvement in perinatal mortality rates associated with cesarean sections under these conditions, it is difficult to indict the present cesarean section rate as an alarming event.

However, as pointed out by Zachman in another issue of this journal[4] there can be undesirable sequelae to cesarean births. These include:

1. Asphyxia.
2. Wet lung disease.
3. Altered blood volume.
4. Iatrogenic respiratory distress syndrome.

In addition there are several possible maternal/family disadvantages. These include:

1. Increased length of separation from the home.
2. Increased financial cost.
3. Psychological problems regarding bonding and negative feelings towards the baby.
4. Increased morbidity.

These factors should certainly be considered when making decisions about cesarean section as the preferred route of delivery; however, based on the information presently available, we must reassure our patients in regards to the indications and safety of the procedure. Erroneous assertions like the risk of death being increased 26 times if a patient undergoes a cesarean section as suggested in the Rhode Island report must be discredited if public confidence is to be maintained.

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Special

Increase in cesarean deliveries in Wisconsin

R D Nashold, PhD, Madison, Wisconsin

In 1935 the cesarean section incidence rate in Wisconsin was 1.7 percent of all deliveries, in the 1940s it was about 2.9 percent,[1,2,3] in the 1950s it rose to 3.7, and by 1967 it reached 4.2 percent. In a little more than three decades the cesarean section rate increased 147 percent. During the next decade, 1968-1977, cesarean section incidence rates rose 145 percent or approximately the same amount as in the previous decades (Table 1). By 1977 cesarean sections represented 10.4 percent of all deliveries.

The trend of rising rates may continue. Wisconsin has rates similar to national levels;[4] however, there are areas of the country where rates are considerably higher. For example, by 1977 cesarean sections in California had reached 15.4 percent of deliveries.[5] This accelerated increase has given rise to discussions that seek to explain and evaluate the trend. As a basis for this discussion it is first necessary to array the available data.

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Advances in fetal medicine including amniocentesis screening and fetal monitoring are frequently cited as contributing factors to recent increases; however, these effects are not altogether clear.[6,7] Obstetricians point out that some part of the current increase in cesarean deliveries may be due to such advances. They also point out that increased cesarean deliveries may lower infant and maternal mortality and that they reduce traumatic forceps deliveries, breech deliveries, prolonged labor and other complications.

It can be noted that when comparing maternal mortality rates for two five-year periods, 1968-1972 with 1973-1977, there has been a 41 percent decline (Table 2). From 1968 to 1977 infant mortality rates declined 42.4 percent (Table 3). Some part of these declines may be attributable to the increase in cesarean sections; however, further research would be necessary to verify this. Moreover, comparative studies between medically advanced countries will, for various reasons, identify areas where both cesarean section rates and infant mortality rates are lower than in the United States.

Table 1—Total deliveries and cesarean sections: Wisconsin 1968-1977

Year	*Total Number of Deliveries*	*Number of Cesarean Sections*	*Cesarean Section Rate* (CSR)*	*Annual Percentage Increase in CSR*	*Percentage Increase in CSR Since 1968*
1968	75,095	3,153	4.20		
1969	75,196	3,437	4.57	8.8	8.8
1970	78,272	3,928	5.02	9.8	19.5
1971	72,743	3,919	5.39	7.4	28.3
1972	65,399	3,812	5.83	8.2	38.8
1973	63,386	4,156	6.56	12.5	56.2
1974	65,729	4,954	7.54	14.9	79.5
1975	65,675	5,350	8.15	8.1	94.0
1976	65,582	6,090	9.29	14.0	121.2
1977	69,026	7,160	10.37	11.6	146.9

*Per 100 deliveries

SOURCE: Summarized from health and medical data on Wisconsin birth certificates, Bureau of Health Statistics, State Division of Health

Table 2—Total deliveries and maternal mortality: Wisconsin 1968-1977

Year	*Total Number of Deliveries*	*Number of Maternal Deaths*	*Maternal Death Rate (MDR)*	*Five Year Average MDR*	*Percentage Change in MDR Between Five-Year Periods*
1968	75,095	9	12.0		
1969	75,196	15	19.9		
1970	78,272	6	7.7	13.4	
1971	72,743	10	13.7		
1972	65,399	9	13.8		-41.0
1973	63,386	7	11.0		
1974	65,729	3	4.6		
1975	65,675	3	4.6	7.9	
1976	65,582	6	9.1		
1977	69,026	7	10.1		

*Rate per 100,000 deliveries

SOURCE: Summarized from health and medical data on Wisconsin birth certificates, Bureau of Health Statistics, State Division of Health.

Table 3—Total live births and infant deaths: Wisconsin 1968-1977

Year	*Total Number of Live Births*	*Number of Infant Deaths*	*Infant Death Rate* (IDR)*	*Annual Percentage Decrease in IDR*	*Percentage Decrease in IDR Since 1968*
1968	74,257	1,453	19.6	-	-
1969	74,324	1,281	17.2	-12.2	-12.2
1970	77,455	1,308	16.9	-1.7	-13.8
1971	71,976	1,157	16.1	-4.7	-17.9
1972	64,719	984	15.2	-5.6	-22.4
1973	62,796	900	14.3	-5.9	-27.0
1974	65,150	898	13.8	-3.5	-29.6
1975	65,145	881	13.5	-2.2	-31.1
1976	65,042	818	12.6	-6.7	-35.7
1977	68,548	774	11.3	-10.3	-42.3

*Per 1,000 live births.

SOURCE: Summarized from health and medical data on Wisconsin birth certificates, Bureau of Health Statistics, State Division of Health.

Table 4—Total deliveries and breech deliveries: Wisconsin 1968-1977

Year	*Total Number of Deliveries*	*Number of Breech Deliveries*	*Breech Delivery Rate* (BDR)*	*Annual Decrease Change in BDR*	*Percentage Decrease in BDR Since 1968-70*
1968	75,095	480		-	-
1969	75,196	555	6.77	-	-
1970	78,272	513		-	-
1971	72,743	N.A.	-	-	-
1972	65,399	N.A.	-	-	-
1973	63,386	324	5.11	-	-24.5
1974	65,729	319	4.85	-5.1	-28.4
1975	65,675	307	4.67	-3.7	-31.0
1976	65,582	290	4.42	-5.4	-34.7
1977	69,026	268	3.88	-12.2	-42.7

*Rate per 1,000 deliveries with a three-year average rate calculated for 1968-1970 because of the fluctuation in the number of breech deliveries for these years.

SOURCE: Summarized from health and medical data on Wisconsin birth certificates, Bureau of Health Statistics, State Division of Health.

Table 5—Total deliveries and forceps deliveries: Wisconsin 1968-1977

Year	Total Number of Deliveries	Number of Forceps Deliveries	Forceps Delivery Rate* (FDR)	Annual Percentage Change in FDR	Percentage Change in FDR Since 1968
1968	75,095	19,475	25.9		
1969	75,196	19,459	25.9	-	-
1970	78,272	19,549	25.0	-3.5	-3.5
1971	72,743	17,493	24.0	-4.0	-7.3
1972	65,399	15,153	23.2	-3.3	-10.4
1973	63,386	13,791	21.8	-6.0	-15.8
1974	65,729	13,498	20.5	-6.0	-20.8
1975	65,675	11,951	18.2	-11.2	-29.7
1976	65,582	10,514	16.0	-12.1	-38.2
1977	69,026	9,708	14.1	-11.9	-45.6

*Rate per 100 deliveries.

SOURCE: Summarized from health and medical data on Wisconsin birth certificates, Bureau of Health Statistics, State Division of Health.

Table 6—Pregnancies and induced abortions reported in Wisconsin 1974-1977

Year	Pregnancies* Excluding Early Spontaneous Abortions	Induced Abortions Reported	Induced Abortion/ Pregnancy Ratio**
1974	76,649	10,920	14.2
1975	77,994	12,319	15.8
1976	79,825	14,243	17.8
1977	84,612	15,586	18.4

*Includes reported live births, fetal deaths and induced abortions
**Per 100 pregnancies

SOURCE: Bureau of Health Statistics, State Division of Health.

With available Wisconsin data, it is apparent that during the past decade there has been approximately a 43 percent decline reported in breech delivery rates (Table 4) and a 45.6 percent decline in reported forceps deliveries (Table 5). To obtain useful data on prolonged labor and other complications in relationship to cesarean section would require a special study. True outcome measures, that is, effects on mothers and infants, are still more difficult to obtain.

It also has been pointed out that over this period unwanted pregnancies are less likely to occur because of the availability of contraceptives and far less likely to come to term because of the increased availability of abortion (Table 6). It has been shown that unwanted pregnancies are more likely to be high-risk pregnancies. High birth order deliveries, which are

Table 7—Total live births and live births of birth order four and above: Wisconsin 1968-1977

Year	Total Number of Live Births	Live Births Birth Order 4+	High Parity (4+) Rate* (HPR)	Annual Percentage Decrease in HPR	Percentage Decrease in HPR Since 1968
1968	74,257	18,621	25.1	-	
1969	74,324	17,066	23.0	-8.4	-8.4
1970	77,455	16,756	22.0	-4.4	-12.4
1971	71,976	14,587	20.3	-7.7	-19.1
1972	64,719	11,657	18.0	-11.3	-28.3
1973	62,796	9,450	15.1	-16.1	-39.8
1974	65,150	8,567	13.2	-12.6	-47.4
1975	65,145	7,992	12.3	-6.8	-51.0
1976	65,042	7,360	11.0	-10.6	-56.2
1977	68,548	7,315	10.7	-2.7	-57.4

*Rate per 100 live births

SOURCE: Summarized from health and medical data on Wisconsin birth certificates, Bureau of Health Statistics, State Division of Health.

also higher risk pregnancies, have continued to decline over the past ten years (Table 7). Therefore, it must be noted that cesarean deliveries have been increasing while the number of high-risk pregnancies has been decreasing.

In an earlier study[2] it was shown that nationally the trend of increasing cesarean section rates is occurring in each of four hospital size groups (small, medium-small, medium-large, large*) in each of the four US census regions (Northeast, North Central, South, West) and in both teaching and nonteaching hospitals. Rates were shown to be higher in larger hospitals and lowest in smaller hospitals.

In Wisconsin, efforts are nearing completion to array cesarean section data by seven Health Service Areas (HSAs), by county, by hospital size group, and by individual hospital. The Division of Health plans in the future to make available to each hospital its own data compared to its hospital size group and Health Service Area. This will provide each hospital additional data for further discussing a 10-year trend in cesarean delivery.

*Hospital size in the study cited is defined by annual number of total discharges:

Small	Less than 5,000
Medium-Small	5,000-9,999
Medium-Large	10,000-14,999
Large	15,000 or more

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MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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Gastrointestinal System Epigastric distress anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses

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If vomiting has not occurred spontaneously, the patient should be induced to vomit This is best done by having him drink a glass of water or milk after which he should be made to gag Precautions against aspiration must be taken, especially in infants and children

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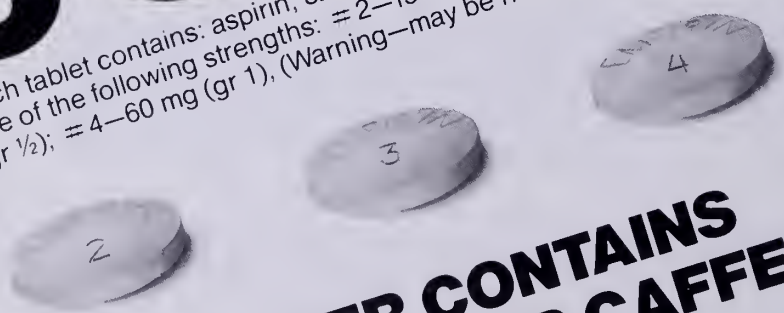

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Cancer Column

Prepared and supported by the Wisconsin Clinical Cancer Center
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Bladder cancer—early detection and diagnosis[1]

BLADDER CANCER arises from one or more transformed urothelial cells. After repeated cell divisions accompanied by reduced cell loss, a lesion gradually develops which occupies space and may cause symptoms. A clinically detectable lesion occupies 1 cm^3 and contains about 10^9 neoplastic cells after about 30 cell divisions. To be lethal, approximately 37 cell divisions are needed, so about 80% of its natural life will have occurred before a tumor causes symptoms leading to diagnosis.

Induction of bladder cancer has discrete temporal stages of initiation and promotion. A histogenetic study of bladder cancer in rats showed that four weeks after beginning a bracken fern diet, the bladder wall thickened and appeared more opaque with red, velvety mucosa. Hyperplasia was apparent after three weeks but histologically reversible despite continued carcinogen administration for an additional 3-4 weeks when the hyperplastic lesions progressed to neoplasia. During the next 4-6 weeks, there was a progressive increase in epithelial hyperplasia, abnormal nuclei, and nuclear chromatin patterns. Squamous metaplasia was observed after 7 weeks. After 8-10 weeks, hyperplastic epithelium showed localized areas of nodular or papillary growth. At 10-12 weeks, a localized proliferative lesion was seen macroscopically. At 12 weeks, epithelial tumors (papillomas or transitional cell carcinomas) appeared. Exposure to two or more carcinogens sequentially or concurrently may elicit an additive or synergistic bladder cancer response.

Bladder neoplasms are heterogeneous and may recur. "Heterotopic recurrence" is the development of new tumors at a site different from the original tumor. They occur in over half of the patients; 15-20% are histologically more aggressive and malignant than the original lesion, suggesting a continuing carcinogenic stimulus. They also may be due to multicentric foci.

[1]Third article in a series on studies being done on bladder cancer at the Wisconsin Clinical Cancer Center in Madison under the leadership of George T Bryan, MD.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or the State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

Early detection and accurate diagnosis of a neoplastic process is necessary if bladder cancer is to be treated successfully. Light microscopy and cystoscopy are the most commonly used methods of detection. Bladder epithelium does not have to be completely disarranged as seen by light microscopy to produce bladder carcinoma; therefore, light microscopy is not an adequate tool for observing early bladder cancer. In rats, malignant transitional cells were not found in the urine by light microscopy until muscle invasion of the tumor was seen histologically. In one study scanning electron microscopic examination of biopsies and exfoliated cells showed abnormal cells, but light microscopy missed 14 of 35. Although bladder malignancy often appears in different regions of the bladder at the same time, well-differentiated carcinomatous cells are often overlooked at cystoscopy.

Dr William Croft of the Wisconsin Clinical Cancer Center recently studied mid-stream urine samples and showed that scanning electron microscopy can detect malignant changes not seen by the other methods. It revealed the loss of organized structures during bladder carcinogenesis. Under low power the surface had a rough appearance. Magnification (up to 30,000 times) showed separation of the cancer cells, a fuzzy appearance of the luminal surface whose microridges had disappeared and which was covered by pleomorphic microvilli of varied length and turgid appearance. Pleomorphic microvilli were never found in patients unless there was bladder malignancy.

The number of detected neoplastic exfoliated cells increased with progressive invasion of the surface mucosa by bladder cancer and with the grade of malignancy. However, the grade of malignancy could not be determined by scanning electron microscopy. A large majority of exfoliated cells shed in the urine with pleomorphic microvilli on their surface retained enough regional surface characteristics to determine their origin. Cells from the lateral wall were large, flat, and highly keratinized, with a smooth surface. Trigone cells were large, round, and thickened, with spade-like microridges. Dome cells were smaller, rounded, plump, 4-6 sided with many intricate fine foldings or small microridges, and cellular junctions that could not be easily seen. Urethral

cells were large, flat cells with long discontinuous microridges arranged in a swirling manner on the surface.

No differences were seen in bladder cells from men or women, with age, or as a result of chronic obstruction. About 65-70% of the shed cells were from the lateral wall, 15-20% from the trigone, 2-5% from the urethra, and 8-10% from the dome.

The method is being used to assess urine of bladder cancer patients for evidence of tumor recurrence and of people at high risk of bladder cancer (*ie,* smokers over 35 years of age or arylamine exposed industrial workers) for cellular atypia and eventual cancer.

In a collaborative study with Dr T Nilsson of Sweden, all bladder cancer patients had cells with pleomorphic microvilli on their surfaces. The greater the bladder surface involvement with tumor, the more cells with pleomorphic microvilli.

Early detection may influence cure rate. Patients with Stage O-A disease have about an 80% five-year survival compared to 20% for other stages. Therefore, efforts must be increased to identify environmental bladder carcinogens, control their dissemination, and develop better ways to diagnose and treat bladder cancer early.

A future CANCER COLUMN will discuss new approaches to this study of bladder cancer.

—**Dorothy J Buchanan-Davidson, PhD**
Science Writer, WCCC■

REVISED STATE IMMUNIZATION LAW

This fall, students in grades kindergarten through 12 and children in day care centers will be subject to a revised state immunization law.

A previous law, passed by the Wisconsin Legislature in 1975, required immunizations for children in day care centers and in grades kindergarten through eight. According to Ivan Imm, Director of the Bureau of Prevention in the Division of Health, the Legislature recently passed a law extending immunization requirements to also include students in grades nine through twelve. The State Medical Society supported the new law.

"The revised immunization law is intended to reduce vaccine-preventable diseases among older children—an age group where, for example, most of the measles cases are now occurring," said Imm.

According to Imm, the revised law also includes a noncompliance penalty through which the local district attorney may seek legal action against the parents of a minor student who does not meet immunization requirements within 30 days of admission. The legal action may include a fine of up to $25 for every day the student is not in compliance and an order for the student to be immunized.

If an outbreak of a disease covered by the law occurs, any child who is not immunized for that disease may be kept out of school. For example, if there is an outbreak of measles, rubella, polio, diphtheria or pertussis in a school, the state Department of Health and Social Services might determine that nonimmunized students should be kept from attending classes until the outbreak subsides.

According to the law, every child must either provide evidence of meeting the immunization requirements or submit a signed waiver claiming health, religious, or personal conviction as reasons for not being immunized. Parents of children who do not comply with the law's requirements within 25 days after the child has been admitted to the day care center or school, will be notified about the noncompliance penalty.

Age-specific immunization requirements will be set this summer and are expected to be:

15 months - 2 years	1 measles, 1 rubella, 3 polio, 3 DTP/Td (diphtheria, tetanus, pertussis/tetanus/diphtheria)
2 - 3 years	1 measles, 1 rubella, 3 polio, 4 DTP/Td
4 years and above	1 measles, 1 rubella, 4 polio, 4 DTP/Td
Kindergarten	1 measles, 1 rubella, 4 polio, 4 DTP/Td
Grades 1 - 6	1 measles, 1 rubella, 3 polio, 3 DTP/Td
Grades 7 - 9	1 measles, 3 polio, 3 DTP/Td
Grades 10 - 12	1 measles

"Children who claim waivers to the immunization requirements but who have received some immunizations should list that information on the back of the waiver form," said Imm.

"This information, in the case of an outbreak of disease, could prevent the child from being kept out of school if vaccine had been received for that disease."

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Organizational SMS

Statewide impaired physician program created

A joint agreement between the State Medical Society and the Medical Examining Board for creation of a statewide Impaired Physician Program has been approved by the SMS Council after negotiation between the Society's Commission on Mediation and Peer Review (CMPR) and the MEB. Among its provisions is establishment of a Coordinating Council on Physician Impairment consisting of three members of the CMPR and three members of the MEB whose assignment will be to establish policies and guidelines for the Impaired Physician Program, coordinate the work of the Society and the Board, and to initiate educational programs in impairment.

SMS appointments to the Coordinating Council are: MDs Gerald C Kempthorne, Spring Green; John B McAndrew, Oshkosh; and Harry F Weisberg, Milwaukee, all members of the CMPR. The Medical Examining Board has appointed MDs Rudolf W Link, Madison; Walter L Washburn, Madison; and Ms Mary Reddin, Wauwatosa, to the Coordinating Council. ■

Nominations for SMS offices must be in by September 28

An early reminder to all SMS physicians that the House of Delegates Nominating Committee will be meeting September 28 to receive nominations for the offices of president-elect, speaker of the House, and AMA delegates and alternates. Nominations, curriculum vitae, and a statement of willingness to serve if elected should be mailed to SMS Secretary Earl Thayer prior to the September meeting date. ■

Open House draws 1000

Nearly 1000 persons visited the Fort Crawford Medical Museum at Prairie du Chien during a three-day "open house" for the residents of Crawford County. Among the visitors were the mayor, city council members, county board, clergy, educators, and others. The Museum is owned and operated by the SMS's CES Foundation. ■

NEWS YOU CAN USE

PHYSICIANS NOTIFY WPS-MEDICARE OF SPECIALTY OR CERTIFICATION CHANGES. Wisconsin physicians are reminded that it is their responsibility, as well as their advantage, to keep WPS-Medicare informed of any change in their specialty or certification status. To alleviate any confusion, each physician should be sure that the same specialty is shown with the various societies; *eg,* AMA, State Medical Examining Board and the State Medical Society. There have been some instances where a different specialty was shown with each organization. Written documentation of such changes should be directed to the WPS-Medicare insurance company office, ATTENTION-CPCU (Central Provider Control Unit). If physicians have any questions concerning the specialty WPS-Medicare currently has on file for them, they should contact Mrs Johnson, CPCU, (608) 221-4711, ext 420.

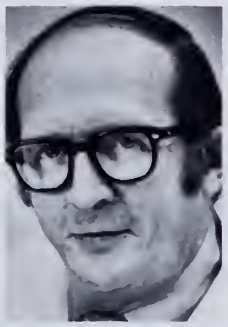
OSHA REQUIRES OPEN HEALTH RECORDS. A decision that could affect millions of workers will become effective August 21 when the Labor Department's Occupational Safety and Health Administration (OSHA) implements a regulation that requires employers to give workers access to company-maintained medical records and all in-house health studies of the workplace. The regulation could affect 25 million workers and hundreds of thousand of companies, some of which bitterly fought the standard during its almost two years of preparation. Business interests fear that unions—which may see individual health records at employees' request—may use the information for suits against companies.

CAN A ROBOT PRACTICE MEDICINE? Not a funny question. A Madison attorney has asked the Medical Examining Board to prosecute a company that puts out coin-operated blood pressure machines, one of which allegedly injured a client's arm when she attempted to get a reading. He is asking whether the device is practicing medicine without a license. The Board says "only a human being is capable of practicing medicine." ■

Dr Dean Connors appointed to WMJ Editorial Board

A Madison pathologist, Dean M Connors, MD has been appointed to the Editorial Board of the *Wisconsin Medical Journal,* replacing Harlan M Levin, MD who resigned after closing his office in Janesville. Doctor Levin spends much of his time in Florida.

Doctor Connors is pathologist and director of the laboratory at St. Marys Hospital Medical Center in Madison. He joined the hospital medical staff in 1959 as associate pathologist and director of medical education following a two-year period as pathologist at the A D Daniels Memorial Laboratory at St. Mary's Hospital in Rhinelander.


Doctor Connors

A native of Hurley, Wisconsin, Doctor Connors graduated from the University of Wisconsin with a BS degree. In 1952 he graduated from the UW-Madison Medical School, then completed a one-year internship at Abington Memorial Hospital in Abington, Pa. He completed four years of postgraduate work in pathology at the University of Minnesota and the University of Wisconsin, receiving his Wisconsin license to practice medicine in 1955. ■

Jailer training courses have excellent reviews

The Jailer Training Courses offered during May at two locations by the State Medical Society of Wisconsin and the University of Wisconsin-Extension Department of Governmental Affairs, were given excellent reviews by those attending. The sessions provided basic training in recognizing and dealing with health and medical problems of the inmates. This four-day course for Wisconsin jail administrators, jailers and nurses working in jails was offered in Madison, May 12-15, and in Wausau, May 19-22.

The course was designed to assist county jails of any size in setting up a medical and health program in conformance with the American Medical Association's Jail Health Care Accreditation Program. The Society has participated in the program for three and one-half years. Nine Wisconsin jails are accredited and 16 other county jails are involved in the program. ■

Exam Board proposes hospital reporting of MD discipline

The Wisconsin Medical Examining Board will propose legislation in 1981 to require hospitals to report certain changes in medical staff privileges in an effort to provide the Board with greater information on physician discipline problems. It is reported that the Board will not require reporting of loss of privileges for voluntary surrender of privileges when these are not related to pending disciplinary actions nor will it require reporting of disciplinary loss of privileges for failure to maintain medical records.

The Board's action took place as a result of a June 13 hearing into the issue. SMS President-elect Albert J Motzel Jr, MD of Waukesha appeared at the hearing to express "support in principle." He supported the concept of "tracking" a physician who loses hospital privileges for healthcare-related disciplinary reasons but recommended more definitive standards as to the type of changes that should be reported. ■

Three resident physicians represent Wisconsin

Wisconsin was represented by three resident physicians at the Fourth Annual AMA Resident Physicians Section Business Meeting in Chicago July 19-20. Doctors Kitty Jewell, Mark Liebow, and Ann Riendl were the Wisconsin delegates based on 1980 AMA Resident Physician Membership of 297. The resident delegates are funded by the State Medical Society. ■

CES FOUNDATION CONTRIBUTIONS—MAY 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1980.

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Membership report as of June 6, 1980

NEW MEMBERS

County Medical Society

BARRON-WASHBURN-BURNETT

Cragg, Michael M, 1020 Lakeshore Dr, Rice Lake 54868 (1948, Regular, Family Physician, Certified)
Eschenbaum, Edward G, 1035 North Main St, Rice Lake 54868 (1938, Regular, Urology, Certified)

DANE

Blume, Peter, 5240 Harbor Court, Madison 53705 (1951, Resident, Internal Medicine)
Bussan, Kenneth L, 20 South Park St, Madison 53715 (1949, Regular, Internal Medicine, Certified)
Celesia, Gastone G, 6722 Colony Dr, Madison 53705 (1933, Regular, Neurology, Certified)
Doeler, Terrence E, 20 South Park St, Madison 53715 (1950, Regular, Anesthesiology)
Dombrowski, Joseph J, Dept of Psychiatry, 600 Highland Ave, Madison 53792 (1945, Resident, Psychiatry/Child Psychiatry)
Durkee, Charles T, 5705 Arbor Vitae Pl, Madison 53705 (1950, Resident Urology)
Kooistra, J Brent, 1 South Park St, Madison 53715 (1946, Regular, Pediatrics/Allergy and Immunology, Certified-PD)
Schwartz, Sheldon M, 1729 Norman Way, Madison 53705 (1951, Resident, Pathology)
Wojtowycz, Myron, 5002 Sheboygan Ave, Apt 148, Madison 53705 (1952, Resident, Diagnostic Radiology)

JEFFERSON

Cochrane, Bruce J, 123 Hospital Dr, Watertown 53094 (1951, Regular, Family Physician)
Detwiler, Alan L, PO Box 47, Fort Atkinson 53538 (1950, Regular, Internal Medicine)

JUNEAU

Ness, D Keith, 205 Division St, Mauston 53948 (1948, Regular, Family Physician, Certified)
Ness, Nancy E B, 205 Division St, Mauston 53948 (1950, Regular, Family Physician, Certified)

KENOSHA

Jeranek, William J, 6530 Sheridan Rd, Kenosha 53140 (1949, Regular, Family Physician, Certified)
Zeihen, Michael, 6310 Fifth Ave, Kenosha 53140 (1947, Regular, Internal Medicine, Certified)

MILWAUKEE

Kamath, M Laxman, 3112 W Highland Blvd, Milwaukee 53208 (1940, Regular, Cardiovascular Surgery/Thoracic Surgery, Certified-TS)
Simons, George W III, 1700 W Wisconsin Ave, Milwaukee 53233 (1935, Regular, Pediatrics/Orthopedic Surgery, Certified-ORS)
Agarwal, Avadh B, 4300 W Burleigh St, Milwaukee 53210 (1931, Regular, Pediatrics)

PIERCE-ST CROIX

Bhatnagar, Vinod K, Rte #2, New Richmond 54017 (1949, Regular, Psychiatry)

WAUKESHA

Blake, David G, 21645 Greendale Dr, Waukesha 53186 (1949, Regular, Internal Medicine/Hematology, Certified-IM)
Hackett, James G, N84 W16889 Menomonee, Menomonee Falls 53051 (1947, Regular, Orthopedic Surgery, Certified-GS)

CHANGE OF ADDRESS

(Does not include those within a city)

ASHLAND-BAYFIELD-IRON

Prentice, John W, Washburn, to 1951 NE 39th St, Lighthouse Point, FL 33064

DANE

Cooper, Garrett A, Green Valley, AZ, to 1512 Sumac Dr, Madison 53705
Crennell, Ean H, Madison, to Riverside Rd, Rte 2, Verona 53593
Straughn, Robert A, San Antonio, TX, to 428 Lily Dr, Madison 53713
Tillman, Ulder J, Madison, to 655 W Baltimore St, Baltimore, MD 21201

DOOR-KEWAUNEE

Hopkins, Richard G, Algoma, to Rte 2, Box 247, Mills Spring, NC 28756

EAU CLAIRE-DUNN-PEPIN

Ebersold, Michael J, Eau Claire, to 945 Greenbriar Rd, SW, Rochester, MN 55901

MILWAUKEE

Craite, Edgar J, Lake Tomahawk, to 105 Summit St, Portage 53901
Holbrook, Arthur A, Sarasota, FL, to 2518 E Lake Bluff Blvd, Milwaukee 53211
Rhomberg, Bernard B, Wauwatosa, to 1160 Lone Tree Rd, Elm Grove 53122
Tomasulo, Peter A, Milwaukee, to PO Box 420100, Miami, FL 33142
Weil, Harry R, Lauderhill, FL, to 3131 E Hampshire St, Milwaukee 53211

OUTAGAMIE

Tatlock, Thomas W, Appleton, to 4320 Wornall Rd, Kansas City, MO 64111

RICHLAND

Tischer, E Paul, Salt Lake City, UT, to PO Box 54, Evansville, IN 47701

WOOD

Freedman, Peter M, Marshfield, to 2 Celeste Dr, Johnstown, PA 16134

COUNTY-TO-COUNTY TRANSFER

Marinette-Florence to Winnebago: Murray, Richard C, 712 Doctors Court, Oshkosh 54901
Milwaukee to Portage: Bergin, Steven C, 2501 Main St, Stevens Point 54481
Milwaukee to Waukesha: La Joie, William J, S32 W27641 Daleview Dr, Waukesha 53186
Sauk to Juneau: Baker, Homer P, PO Box 128, Wonewoc 53968
Wood to Kenosha: Bhattacharyya, Sisir K, 5942 Sixth Ave, Kenosha 53140

DEATHS

Quilling, Philip A, Eau Claire-Dunn-Pepin County, Nov 9, 1978
Seng, Wilfrid L, Milwaukee County, Mar 3, 1980
Buckley, Clarence H, Eau Claire-Dunn-Pepin County, Mar 17, 1980
Freeman, Joseph M, Marathon County, Apr 3, 1980
McGarty, Matthew A, LaCrosse County, Apr 13, 1980
Hittner, Vernon J, Outagamie County, Apr 16, 1980
Gray, Rodney J, Rock County, Apr 17, 1980
Caton, Joseph R, Milwaukee County, Apr 24, 1980
Balliet, Charles M, Marathon County, Apr 27, 1980
Maloof, George J, Dane County, Apr 30, 1980
Davis, Nathan S, Manitowoc County, May 3, 1980 ■

Obituaries

◊ County, State, AMA Members

◊ **Wilfrid L Seng, MD,** 82, Milwaukee, died Mar 3, 1980 in Milwaukee. Born Feb 2, 1898 in Milwaukee, Doctor Seng graduated from Marquette University School of Medicine in 1930. He also had a degree in dentistry and had served on the professional staffs of St Mary's and Milwaukee Lutheran hospitals. He also was a faculty member of the Marquette University Dental School. Doctor Seng retired in 1967. Surviving are two daughters, Sister Marie, Sinsinawa, and Mary Roob, Milwaukee; and two sons, Joseph F, Rockville, Md, and Dr Mark W of Austin, Tex.

◊ **Clarence H Buckley, MD,** 75, Eau Claire, died Mar 17, 1980 in Eau Claire. Born July 18, 1904, Doctor Buckley graduated from the University of Minnesota Medical School in 1933. He served his internship at Grant Hospital, Chicago, Ill. He served in the United States Army Medical Corps from 1942 -1946. Surviving is his widow.

◊ **Robert M Senty, MD,** 57, Sheboygan, died Mar 21, 1980 in Sheboygan. Born Aug 22, 1922 in LaCrosse, Doctor Senty graduated from the University of Wisconsin Medical School, Madison, in 1947. He served his internship and residency at the Charles T Miller Hospital, St Paul, Minn. He also did post-graduate work at the Army Medical Service Graduate School, Walter Reed Hospital, Washington, D C. He had served as a captain in the United States Army Medical Corps from 1948 - 1954. He became a member of the medical staff of the Sheboygan Clinic in 1954 and practiced there until illness forced him to retire in 1978. In 1965 he served as president of the Sheboygan County Medical Society and in 1969 he was elected a director of the alumni board of the University of Wisconsin. He was medical director of the We Care Nursing Home and a member of the Sheboygan Board of Health. Doctor Senty was the Sheboygan area preceptor for the University of Wisconsin Medical School from 1958 -1975, and a recipient of the Max Fox Preceptor Award. He also served as vice president of the State Medical Society's Charitable, Educational and Scientific Foundation.

Surviving are his widow, Alice; a daughter, Mrs. Michael (Carolyn) Stieghorst, Madison; and two sons, David and Robert of Arlington, Va.

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◊ **Joseph Martin King, MD,** 87, Milwaukee, died Mar 31, 1980 in Milwaukee. Born May 10, 1892 in Milwaukee, Doctor King graduated from Marquette University School of Medicine in 1920. He joined the staff of Milwaukee County General Hospital in 1919 while he was a senior in medical school. He served his internship and residency in surgery at Milwaukee County General Hospital. He joined the medical school faculty in 1925 and in 1935 was appointed director of surgery. He retired as the director of surgery in 1962, and is credited with training more than 360 area surgeons in the surgical residency program. For more than 35 years he was a member of the Marquette Medical School faculty. He held the rank of Clinical Professor of Surgery, Emeritus, at Marquette. In 1967 he was named Marquette University Alumnus of the Year. In November and December of 1973, the *Wisconsin Medical Journal* published "Festschrift" issues in honor of Doctor King. He was a member of the Founder's Group of the American Board of Surgery and a fellow of the American College of Surgeons. He was a founding member of the Wisconsin Surgical Society and served as president in 1957.

Surviving are his widow, Irene; two daughters, Mary Elizabeth O'Meara, LaCrosse; Jane Guhl, Elm Grove; four sons, James, Mequon; Patrick and John, Wauwatosa, and Thomas of Stone Bank.

◊ **Joseph M Freeman, MD,** 89, Wausau, died Apr 3, 1980 in Wausau. Born Nov 17, 1891 in Sullivan, Ind, Doctor Freeman graduated from Harvard Medical School in 1918. He served his internship at Barnes Hospital in St Louis, Mo, and had been in medical practice in Wausau since 1919. He had served as both secretary-treasurer and president of the Marathon County Medical Society, the former 9th Councilor District Medical Society, and the Wisconsin Society of Obstetrics and Gynecology. He served as chairman of the Commission on Scientific Medicine and in 1968 became a member of the "50 Year Club" of the State Medical Society of Wisconsin. Doctor Freeman was associate preceptor-University of Wisconsin Medical School for many years and also served as chief of the Department of Obstetrics and Gynecology at Wausau Memorial Hospital. Surviving are two daughters, Mary Jean, Wausau, and Eleanor F Johnson, Chicago, Ill; and a son, D J Freeman, MD of Wausau.

◊ **Matthew A McGarty, MD,** 90, long-time LaCrosse surgeon and former president of the State Medical Society of Wisconsin from 1920 - 1921, died Apr 13, 1980 in LaCrosse. Born June 22, 1889 in Mauston, he graduated from Marquette University School of Medicine in 1912 and served two years internship at Milwaukee County General Hospital, and did postgraduate studies at Harvard Medical School, Johns Hopkins University, and the Cleveland Clinic. Doctor McGarty served in the United States Army Medical Corps from 1916 -1918. He was a member of the American College of Surgeons, the American Board of Surgery, and was a preceptor for 30 years for the University of Wisconsin Medical School, Madison. He also served as president of the LaCrosse County Medical Society.

Surviving are a daughter, Mrs Richard (Ellen) Flynn of Sturbridge, Mass, and a son, the Reverend Bernard McGarty of LaCrosse.

◊ **Vernon James Hittner, MD,** 81, Seymour physician since 1923, died Apr 16, 1980 in Green Bay. Born Oct 1, 1898 in Seymour, Doctor Hittner graduated from Rush Medical College in 1923. He served the Seymour area as a general surgeon and family practitioner from the time he completed his internship until he died. He served in the United States Army during World War I. In 1973 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin. He also was a member of the World Medical Association, the Royal Society of Medicine, London, England, the American Society of Abdominal Surgeons, the American Association of Railway Surgeons, and the International Academy of Proctology and Colon Surgery. He was a fellow of the American College of Surgeons and the Internal College of Surgeons. Surviving are his widow, Catherine; a son, James, Loe Gatos, Calif, and a daughter, Mrs Nancy Adamski of De Pere.

◊ **Rodney Jones Gray, MD,** 79, Evansville, died Apr 17, 1980 in Madison. Born Nov 18, 1900 in DeForest, Doctor Gray graduated from Washington University School of Medicine, St Louis, Mo, and served his internship at Madison General Hospital. Doctor Gray practiced in Brooklyn from 1926 to 1946 when he moved to Evansville. In 1976 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are his widow, Iona; two sons, Roger Gray, MD, Evansville and Lewis Gray of Arlington Heights, Ill; and a step-son, Gene Dougherty of New Berlin. He was preceded in death by his first wife, Helen Sloan Gray, in 1968.

◊ **Joseph R Caton, MD,** 67, Milwaukee, died Apr 24, 1980 in Milwaukee. Born Feb 18, 1913 in Logansport, Ind, Doctor Caton graduated from St Louis University, St Louis, Mo, in 1932. His internship and residency were served at St Louis City Hospital. He served in the United States Army Medical Corps from 1942 - 1946. Surviving are three daughters, Mrs Joan Anthony, Mrs Susan Casper, Carol Caton Schwartz; and one son, Joseph R.

◊ **Charles M Balliet, MD,** 58, Wausau, died Apr 27, 1980 in Wausau. Born July 4, 1921 in Appleton, Doctor Balliet graduated from Marquette University School of Medicine in 1946 and served his internship at Deaconess Hospital, Milwaukee, and his residency at Lankenau Hospital in Philadelphia. He then became a member of the Stahmer Clinic until entering the Korean War. After the war, Doctor Balliet returned to Wausau and established his own family practice until joining the Wausau Medical Center in 1967. He was a diplomate of the American Academy of Family Practice, served as chief-of-staff at St Mary's Hospital in Wausau, and was president of the Marathon County Medical Society in 1972. Surviving are his widow, Maxine; two sons, James, Milwaukee, and Kelly at home; and three daughters, Mrs Arthur (Mary) Forsberg and Susan, both of Wausau, and Joan of Tucson, Ariz.

◊ **George J Maloof, MD,** 74, Madison, died Apr 30, 1980 in Milwaukee. Born Sept 11, 1905 in Peoria, Ill, Doctor Maloof graduated from the University of Wisconsin Medical School in 1933. His internship was served at Milwaukee County Hospital. He was a former associate professor of anatomy at the University of Wisconsin before entering into private practice and general surgery. Doctor Maloof was a member of the International College of Surgeons. He was a member of the medical staff of the Methodist Hospital. Surviving are his widow, Elizabeth; a son, George of Washburn; and two daughters, Patty and Betsy, both of Madison, and a grandson.

◊ **Nathan S Davis, MD,** 55, Manitowoc, died Apr 28, 1980 in Manitowoc. Born June 11, 1924 in Chicago, Ill, Doctor Davis graduated from Harvard Medical School in 1947 and served his internship at Wesley Memorial Hospital, Chicago. He served in the United States Army Medical Corps from 1951-1953. He had been affiliated with the Park Medical Center, Manitowoc, since 1954. Doctor Davis had served as chief of the medical staff of Holy Family Hospital and had also served as president of Manitowoc County Medical Society in 1971. Surviving are his widow, Naomi, and four children. ■

County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

ADAMS-COLUMBIA-MARQUETTE: New officers of the Tri-County Medical Society for the year 1980-81 are as follows: MDs Victor C Guzman Jr,* president; Thomas E. Henney,* president-elect; Fredrik H Bronson,* secretary-treasurer; and Robert T Cooney,* all of Portage, delegate to the State Medical Society of Wisconsin. Martin Janssen, MD* Adams-Friendship, is the alternate delegate to the State Medical Society.

DANE: At its June 3 meeting the Board of Directors of the Dane County Medical Society Foundation for Medical Research approved a grant to be awarded to conduct a research project this summer in the following areas: (1) effectiveness of the Medication Card, (2) public relations, (3) membership recruitment, and (4) public education and the public's perception of medicine. Peter Meyer, a freshman medical student at the University of Wisconsin-Madison, will be awarded a grant to conduct the research in these areas over an eight-week period. The results of this project will be reported to the Foundation directors upon its completion.

Final arrangements have been made for the DCMS and its Auxiliary Fall Fling Dinner-Dance, October 18, at the Maple Bluff Country Club. The American "Swing" Express, a nine-member group consisting of members of the larger American Jazz Express, will provide music for dancing. Neighborhood preprandial parties also are being planned.

New members are: MDs Walter Baranowski* (orthopedics) of East Madison Clinic; Janis Ellen Byrd* (family practice) in Sun Prairie; Sheila K Carlson* in residency at UW-Madison; Robert L Cole* (family practice) at Odana Medical Center, Madison; Laryssa N Kaufman* presently at the UW-Madison on a Stetler Research Fellowship; Mario Contreras* in a pathology residency at Madison General Hospital; Klaus D Diem* with Madison Obstetrics and Gynecology; Charles B Godfrey* in psychiatry residency at UW-Madison; John A Kozarek* with the University Radiology and Nuclear Medicine Associates; and James P Wise* (ophthalmology) with Doctors Oosterhous and Andrew in Madison.

PIERCE-ST CROIX: The Pierce-St Croix County Medical Society has approved a $1000 contribution to the CES Foundation of the State Medical Society. The contribution is to be earmarked for an endowment fund, the income of which will be used solely for support of the medical museum in Prairie du Chien. The museum is operated by the SMS's CES Foundation. The County Society has been active in collecting artifacts and other historical materials for the museum.

GREEN: New officers of the Green County Medical Society for the year 1980-81 are as follows: MDs Geoffrey Tullet,* Monroe, president; and George E Breadon,* Monroe, secretary-treasurer.

WINNEBAGO: Robert E Condon, MD* of the Medical College of Wisconsin in Milwaukee addressed the Winnebago County Medical Society on the subject, "Preparation of the Bowel for Surgery of the Colon." There were 44 members present at the June 5 meeting in Menasha. Four physicians were accepted to membership: John S Boyle, MD,* John M Elisberg, MD,* and David H Romond, MD,* all of Oshkosh; and E Robert Taake, MD* of Neenah. The next meeting will be held in September. ■

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Specialty Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

American Academy of Pediatrics, in recognition of 50 years of advocacy of children's health and welfare, has adopted 10 National Child Health Goals and published them in a booklet entitled, "An Agenda for America's Children," centerpiece of the Academy's Anniversary year program. Through support of Academy chapters at the state and local levels, the Academy hopes to increase public awareness of the serious health problems confronting our nation's children, an Academy release noted. The following 10 National Goals have been selected by the Academy as action initiatives throughout 1980 and for the future:

- All children should be wanted and born to healthy mothers.
- All children should be born well
- All children should be immunized against the preventable infectious diseases for which there are recommended immunization procedures.
- All children should have good nutrition.
- All children should be educated about health and health care systems.
- All children should live in a safe environment.
- All children with chronic handicaps should be able to function at their optimal level.
- All children should live in a family setting with an adequate income to provide basic needs to insure physical, mental, and intellectual health.
- All children should live in an environment that is as free as possible from contaminants.
- All adolescents and young people should live in a societal setting that recognizes their special health, personal, and social needs.

President of the Wisconsin Chapter of the AAP is Kenneth O Johnson, MD of Milwaukee; Ordean L Torstenson, MD* of Madison is the secretary.

The SMS Specialty Section on Pediatrics is chaired by Curtis R Weatherhogg, MD* of Madison. Richard L Myers, MD* of Green Bay and William H Bartlett, MD* of Madison are serving as delegate and alternate delegate, respectively, to the SMS House of Delegates.

Wisconsin Surgical Society will conduct its fall meeting Friday-Saturday, September 12-13, in Lake Geneva. Further details will be published as soon as available. New officers of the WSS elected for the year 1980-81 are:

President—Charles E Yale, MD,* Madison
Past President—Walton D Thomas, MD,* Milwaukee
President-elect—Henry F Twelmeyer, MD,* Wauwatosa
Secretary-treasurer—Richard B Windsor, MD,* Sheboygan
Recorder—Johan A Mathison, MD,* Oshkosh

Members of the Council are:

Louis C Bernhardt, MD*, Madison—1981
Gale L Mendeloff, MD,* Milwaukee—1981
Earl B Kitzerow, MD,* Appleton—1982
Stuart B Wilson, MD,* Milwaukee—1982
Robert E Condon, MD,* Milwaukee—1983
James E Gutenberger, MD,* Madison—1983

Officers of the Specialty Section on Surgery of the State Medical Society of Wisconsin elected for the year 1980-81 are:

President—Charles E Yale, MD,* Madison
Vice President—Henry F Twelmeyer, MD,* Wauwatosa
Secretary—Richard B Windsor, MD,* Sheboygan
Delegate to SMS—J David Lewis, MD,* West Bend
Alternate Delegate to SMS—Louis C Bernhardt, MD,* Madison

Wisconsin Academy of Family Physicians at its June meeting elected the following officers: MDs John O Grade,* Elm Grove, president; Charles Steidinger,* Platteville, president-elect; Jack Strong,* Mauston, secretary-treasurer; William Wright,* Mondovi, speaker, Thomas H Peterson,* Wausau, vice-speaker, and Mr Robert H Herzog, Elm Grove, executive secretary.

American College of Physicians in May elected the following new fellows from Wisconsin: MDs Thomas W Chuprevich, Green Bay; William R Friedenberg* and W Bruce Fye,* Marshfield; and Abe J Sosman, Milwaukee.

NEWS YOU CAN USE

REVISED IMMUNIZATION LAW. The Legislature recently passed a law extending immunization requirements to also include students in grades nine through twelve. A previous law, passed in 1975, required immunizations for children in day care centers and in grades kindergarten through eight. The State Medical Society supported the new law. Further details appear elsewhere in this BLUE BOOK issue. ■

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Muhammad Y Ahmad, MD,* Merrill, recently was notified by the American Board of Surgery, Inc, that he had successfully completed his certifying examination. Doctor Ahmad is a member of the medical staff of Merrill Medical Associates, SC in Merrill.

James T Gariti, MD, formerly of Fullerton, Calif, recently became a member of the medical staff of Eagle River Memorial Hospital. Doctor Gariti graduated from the University of Illinois Medical School and completed his residency in family practice at the MacNeal Memorial Hospital, Berwyn, Ill. He is a diplomate of the American Board of Family Practice.

Lance Zernzach, MD, Omro, recently opened his medical practice at the Omro Medical Clinic. A graduate from the University of Wisconsin Medical School, Madison, Doctor Zernzach completed his family practice residency at St Mary's Medical Center in Madison. Prior to joining the Omro Medical Clinic, he had practiced in Mauston.

Melvin F Huth, MD,* Baraboo, medical director at St Clare Hospital, recently delivered the Memorial Day address at the traditional Memorial Day observance in Wisconsin Dells. Doctor Huth has had 30 years of military service and served for five years in the European Theater during World War II. Besides holding the rank of colonel in the Army, Doctor Huth is currently a member of the Editorial Board of the *Wisconsin Medical Journal* and also is a member of the Commission on Peer Review of the State Medical Society of Wisconsin. He maintains his own medical clinic in Baraboo.

Clyde E Siefert, MD,* Oconto Falls (left) is shown above receiving an engraved Golden Hour Clock from sales representative Mr Patrick D Quinn (right) of Abbott Laboratories. Abbott Laboratories presented Doctor Siefert the clock for his 25 years of outstanding service and dedication to medicine.

Nicholas L Owen, MD,* Brookfield, recently was presented a special award for outstanding contributions to the aging during the spring conference and annual meeting of the Wisconsin Association of Homes for the Aging, Inc. Doctor Owen is an associate clinical professor of medicine at the Medical College of Wisconsin and currently serves as medical director of Methodist Manor Inc, West Allis, and the Milwaukee Protestant Home for the Aged.

William B Ledlie, MD, Mayville, recently became associated with the medical staff of Flyway Medical Clinic, it was announced by John A Smith, MD,* medical director. Doctor Ledlie graduated from the University of Texas Medical Branch in Galveston and served his family practice residency in the Memorial Hospital System in Houston. For the past two years he has been in private practice in Lake Jackson, Tex.

Bruce J Brewer, MD* Waukesha, recently received the "Alumnus of the Year" award at the Marquette-MCW Alumni Association banquet. Doctor Brewer is chairman of the Department of Orthopedic Surgery at the Medical College of Wisconsin and has been on the faculty since 1949. He is a past president of the Milwaukee Surgical Society and is on the board of governors of the American College of Surgeons.

William Offenkrantz, MD, Chicago, recently became associated with the Medical College of Wisconsin as professor of psychoanalysis and psychiatry and director of the Division of Psychoanalysis. Doctor Offenkrantz, who was a member of the faculty at the University of Chicago School of Medicine for 22 years, is currently the only professor of psychiatry and psychoanalysis in the United States. The purpose of his joining the faculty is to establish the Wisconsin Psychoanalytic Institute.

Laurence J Logan, MD,* LaCrosse, recently was appointed to the Wisconsin Council on Hemophilia and Related Blood Disorders. Doctor Logan is president of the Lutheran Hospital medical staff and has been a member of the Gundersen Clinic since 1973. He also is the director of the Hemophilia Treatment Satellite Center in LaCrosse.

Michael Evans, MD, River Falls, has joined the staff of the River Falls Medical Clinic in the department of surgery. He graduated from the University of Utah Medical School in 1970 and served his internship and residency training at Brooke Army Medical Center in San Antonio, Tex. Prior to joining the Clinic, he had been in private practice in American Fork, Utah.

Patricia J Stuff, MD,* Bonduel, recently spoke at a seminar on "Women in the 80's" held in Shawano. Her topic was "Issues in Women's Health Care." Doctor Stuff graduated from The Medical College of Pennsylvania and served as the vice-speaker of the House of Delegates of the State Medical Society in 1973. She was the first woman officer of the Society and in 1971 she received the "Woman of the Year" Award from the Shawano County Business and Professional Women's Association. She was a member of the Ad-Hoc Committee on Women's Health Issues—State Medical Society in 1979 and currently is the chairman of the AMA Ad-Hoc Committee on "Women Physicians in Organized Medicine."

Samuel J Otto, MD,* Milwaukee, recently completed all requirements for the American Board of Urology. He graduated from the University of Wisconsin Medical School, Madison, in 1971, served an internship at York Hospital, York, Pa, completed two years as a flight surgeon in the United States Air Force, and completed his residency training at the Medical College of Wisconsin. Doctor Otto is associated with MDs John D Silbar,* Stuart W Fine,* and Barry H Usow,* at the Clinic of Urology in Milwaukee.

Gerald J Derus, MD,* Madison, recently was inducted into the Kaukauna Sports Hall of Fame. A four letter winner in track and a pair of letters in basketball in high school, Doctor Derus founded the Monona Grove Clinic, Madison in 1953, served as president of the State Medical Society, Dane County Medical Society, and is a delegate to the American Medical Association. At Kaukauna High School, he was the recipient of the Lang Trophy as the outstanding senior.

Walter Jaeschke, MD,* professor of pathology at the University of Wisconsin Medical School, Madison, retired July 1 with the status of emeritus professor. Doctor Jaeschke graduated from the UW Medical School in 1934 and completed his residency in internal medicine in 1937. In 1941 he became Board certified in pathology and was named director of laboratories at St Agnes Hospital in Fond du Lac. In 1942 he returned to Wisconsin as an assistant professor of clinical pathology; and after his retirement July 1, he plans to develop a series of lectures and slides on breast pathology for teaching medical students.

James L Carroll, MD and **James Kirchhoffer, MD,** Tomahawk, recently joined the medical staff of Sacred Heart Hospital. Doctor Carroll is a 1977 graduate of the University of Michigan Medical School and did his residency training in family practice at the University of Alabama, Tuscaloosa. Doctor Kirchhoffer graduated from Hahnamann Medical College, Philadelphia, and served his residency training at Bridgeport Hospital, Conn.

Manucher Javid, MD,* professor and chairman of the Division of Neurological Surgery at the University of Wisconsin, Madison, recently was invited to become a founding member of the newly formed Xeiron Society. The new society was formed to recognize and promote original significant work in neurological sciences by neurological surgeons throughout the world. The Xeiron Society has a total membership of 10, six of whom are from the United States, two from Canada, and two from Europe.

Richard J Boxer, MD,* Milwaukee, recently became a member of the medical staff of the Ozaukee Medical Center, Thiensville. Doctor Boxer graduated from the University of Wisconsin Medical School, Madison, and served an internship at Harbor General Hospital in California. His residency training was at Wadsworth Veterans Hospital, Los Angeles, and UCLA Medical Center. He currently is a clinical instructor at the Medical College of Wisconsin.

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Bayard Frederick, MD,* Park Falls, recently became associated with the Lakeland Medical Associates to practice internal medicine at the Park Falls Clinic and the Flambeau Medical Center. He graduated from the University of Wisconsin Medical School, Madison, and served his residency at St Joseph's Hospital and the Marshfield Clinic.

John R Allen, MD,* medical director of the Wausau Medical Center, recently represented that organization in a recent leadership conference sponsored by the American Academy of Medical Directors held in White Sulphur Springs, W Va. The conference brought together medical directors from large healthcare groups throughout the country, as well as recognized faculty from business and healthcare organizations throughout the nation. Doctor Allen participated in workshops dealing with health laws, new services to meet changing consumers' wants and needs, organization power and politics, and the role of the physician executive, among others.

Jeffrey Thomas, MD,* orthopaedic surgeon at the Janesville Medical Center, Janesville, recently received the Second Annual Athletic Service Award presented at the June 3 Banquet of Champions. The award is given to an individual who has distinguished himself by giving an extraordinary amount of time and talents to the promotion and improvement of Janesville Athletics. Doctor Thomas has been active in the Janesville Sports Medicine Program for over seven years. He has served as liaison between the school and the medical community, is currently conducting a workshop for athletic trainers and is chairman of the Sports Medicine Committee at Mercy Hospital, Janesville.

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Wisconsin Medical Alumni Association of the University of Wisconsin Medical School, Madison, recently announced its new officers for 1980-81. John T Brennan, MD,* a 1967 graduate of the UW Medical School and an internist with the Skemp-Grandview Clinic, LaCrosse, is president. He succeeds Dorothy Wittman Betlach,* Janesville. Burton M. Zimmermann, MD,* chief of the Department of Family Medicine and Practice at Mt Sinai Medical Center, Milwaukee, was named president-elect. Elected to three-year terms on the board of directors are: MDs George Behnke,* Kaukauna; Lynn Eggman,* Rhinelander; and Walter Schwartz,* Milwaukee.

The University of Wisconsin Medical School, Madison, in an attempt to attract top-notch Wisconsin students, has instituted an early admissions program. The first class of 20 students will be admitted in September 1981. UW Medical School faculty members recently voted to accept highly qualified high school seniors in the program during the spring semester of their final year. After two or three years of college or completion of a baccalaureate degree, students who meet program requirements will enter medical school. Students must complete all undergraduate requirements at the University of Wisconsin, Madison. Admission to the program will be restricted to Wisconsin residents with excellent high school records and SAT scores of 1300 and above. Acceptance also will be based on the student's liberal arts education, including social sciences, foreign languages, and the humanities.

Trinity Memorial Hospital, Cudahy, recently announced its new officers for 1980. They are MDs Vito N Vitulli,* South Milwaukee, chief-of-staff; Anne Fagan, Greenfield, vice-president; Romeo Biboso,* Greendale, secretary-treasurer; Robert C Tabet,* Cudahy, president-elect; and Harold A Jacobsohn,* Cudahy, chief of surgery.

Milwaukee Psychiatric Hospital recently changed the name of the Doctors' Building to Lorton Professional Building. The name was selected by the hospital to honor the memory of Rhoda E Lorton, MD and to honor William L Lorton, MD* for his 22 years of service to the hospital. Dr. Rhoda E Lorton suffered a fatal knife wound inflicted by a patient last June in her office. Milwaukee Psychiatric Hospital is observing its 95th anniversary.

The Wisconsin Medical Alumni Association recently honored alumni and former faculty members for significant contributions to medicine at its annual meeting. The late Ralph M Waters, MD, chairman of the University of Wisconsin Medical School Department of Anesthesiology from 1927 - 1949, was posthumously awarded an Emeritus Faculty Award. Doctor Waters is credited with building the anesthesiology program at the UW Medical School, and under his direction the Department of Anesthesiology became a model for medical schools around the world. Peter A Duehr, MD,* UW Medical School emeritus professor of ophthalmology, also received an Emeritus Faculty Award. During his career, Doctor Duehr divided his time between teaching at the UW and an ophthalmology practice at the Davis-Duehr Eye Clinic. Matthew Davis, MD,* chairman of ophthalmology, announced that over $100,000 in gifts and pledges have been received to establish and endow a Peter A Duehr Professorship in Ophthalmology.

Jackson Clinic, Madison, physicians recently elected its board of directors for 1980-81. John H Morledge, MD,* staff physician since 1959 and an officer on the board of directors of the Jackson Foundation for Medical Research and Education, was elected president. Other officers are MDs Paul A McLeod,* first vice-president; Patricia Joo,* second vice-president; Klaus D Backwinkel,* third vice-president; Norval E Bernhardt,* secretary; and Barbara A Brew,* treasurer. Blake E Waterhouse, MD* remains as the medical director.

Six University of Wisconsin Medical School faculty members received the Medical Alumni Association's Award for Distinguished Teaching at the annual alumni meeting held in May. The 1980 recipients are MDs Dennis G Maki, associate professor of medicine; Gary D Anderson, Department of Human Oncology; and James C Pettersen, PhD, associate professor of anatomy, all of Madison. Clinical faculty members to receive awards are MDs Joseph J Mazza,* clinical assistant professor of medicine, Marshfield Clinic; Phillip R Hamilton, clinical assistant professor of obstetrics and gynecology, Mt Sinai Hospital and Medical Center, Milwaukee; and A C V Elston, clinical assistant professor of pediatrics, Gundersen Clinic, LaCrosse.

New London Community Hospital, New London, recently announced its election of new officers for 1980-81. They are MDs Lloyd P Maasch,* Weyauwega, president; Luis L Galang,* New London, vice president; and David A Hammes,* New London, secretary-treasurer.

The Medical College of Wisconsin recently awarded three faculty members with Distinguished Service Awards at its 68th commencement ceremonies held in May. Receiving awards were: B Wesley Catlin, PhD, professor of microbiology; Frederick W Madison, MD,* clinical professor of medicine; and Marvin Wagner, MD, clinical professor of surgery. Doctor Madison, a specialist in internal medicine, graduated from Columbia University's College of Physicians and Surgeons. He has served as the ideal physician role model for medical students and young physicians in training at MCW for over 50 years.

Wisconsin State Medical Golf Association will have its fall golf outing Thursday, September 18, at the Racine Country Club, with starting tee-off time at 9:00 am. Dinner will be at 6:30 pm. Prizes and a trophy will be awarded. A fee of $35 includes dinner, prizes, and golf. Any Wisconsin physician interested should contact Ronald Oschman, WSMGA, 401 West Michigan Ave, Milwaukee, Wis 53201; phone 414/226-6151.

Deaconess and Milwaukee Lutheran hospitals' boards of directors have agreed to a merger of the institutions, according to an announcement from Deaconess Hospital. The merger is intended to pave the way for establishment of a downtown medical center of 500-600 beds at a site yet to be determined. Still subject to approval by the corporate bodies of the two hospitals, as well as regulatory agencies, the plan calls for consolidation of all programs, services and assets, with Deaconess President Kenneth S Jamron assuming the position of president and chief executive officer of the merged institution. Full cooperation was also assured Milwaukee Children's Hospital, which has expressed a desire to remain independent but to relocate on the campus of a combined Deaconess-Lutheran facility. Both the site and a name for the new medical complex will be left to the new board of directors, to be composed of representatives from both hospitals. The initial chairman and secretary will be elected from the Deaconess representatives and the vice chairman and treasurer from Lutheran. The announcement quoted Mr Jamron as stating that he envisions a complete medical center that would utilize "not only the latest in healthcare delivery systems but also the most economical, energy-efficient technology available."

Tenuate® ℞
(diethylpropion hydrochloride NF)
Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon (Dillon), R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404

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Each capsule contains
5 mg chlordiazepoxide HCl
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antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

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consult complete prescribing informa- summary of which follows:

cations: Based on a review of this by the National Academy of nces—National Research Council or other information, FDA has classi- the indications as follows: ibly" effective: as adjunctive therapy e treatment of peptic ulcer and in the ment of the irritable bowel syndrome ble colon, spastic colon, mucous col- nd acute enterocolitis. classification of the less-than- tive indications requires further tigation.

dications: Glaucoma, prostatic hyper- enign bladder neck obstruction; hyper- y to chlordiazepoxide HCl and/or Bromide

s: Caution patients about possible com- ects with alcohol and other CNS nts, and against hazardous occupations complete mental alertness (e.g., operat- inery, driving). Physical and psychologi- ndence rarely reported on recommended t use caution in administering Librium® zepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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Overweight may not always be simple... complications can develop.*

Complicated or not...

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A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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For prescribing information see opposite

WPS

report

for Wisconsin Physicians

Volume IX, Number 4

July, 1980

HEALTH EDUCATION FILMS

Effective health education is often aided by visually interesting, dramatic expositions of the personal nature of health. WPS offers four films on significant preventive health issues to interested individuals, organizations and community groups. Each can be adapted to appropriate patient education activities.

YOU CAN'T BUY HEALTH is a 27 minute, color, 16 mm film that selects a variety of health promoting activities -- such as fitness classes for the elderly, exercise trails and cardiac rehabilitation programs -- to demonstrate that people can take action to protect their health. In addition to emphasizing that lifestyle health habits can help protect an individual from illness, the film also points out the apparent cost savings for a nation that is healthy and more fit.

SMOKING: HOW TO STOP is a 26 minute, color, 16 mm film that follows the day-to-day difficulties of a young woman who is giving up smoking. Viewers can observe various behavior modification techniques and can better appreciate the importance of support and understanding from family members and friends in breaking this habit. This film is an appropriate introduction to a smoking cessation group.

THE OTHER GUY is a two part, color, 16 mm film, each part running 27 minutes. The film depicts the life of an executive whose excessive social and business drinking leads to alcoholism. With help from family and health professionals, the executive follows the often difficult path to recovery.

SUICIDE: THE WILL TO DIE is a two part, color, 16 mm film, each part running 27 minutes. The film presents general information and statistics on suicide and the true case history of a woman who has had three unsuccessful suicide attempts.

The films are available for one-week loans. To order a film, write to the Communications Division, WPS, P.O. Box 8190, Madison, WI 53708. If there is a conflict in scheduling for those two weeks, WPS staff will contact you to arrange another date.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

HEALTH EDUCATION FILMSTRIPS

In addition to the 16 mm films in the WPS health education library, WPS has acquired four 35 mm filmstrips available for loan which also concern preventive health issues. Each filmstrip is accompanied by a synchronized audio cassette tape approximately 25 minutes in length. These filmstrips and cassettes are designed to be played on 35 mm projectors with synchronized tape capability.

Although designed to be accompanied by printed material (not supplied), the filmstrips and cassettes on their own are useful supplements to patient education activities.

Smoking: What Your Doctor Wants You to Know

Using a father and his son as main characters, this filmstrip provides information about how smoking affects the body, including the relationship between smoking and cancer and other diseases. The benefits of stopping smoking are also discussed.

Alcohol: What You Should Know

Through depicting a middle-aged man and woman in a variety of settings, this filmstrip covers the effect of alcohol addiction and its treatment.

You Can Stop Smoking: Ways To Do It

This filmstrip depicts a man in his early thirties who is learning to stop smoking. He faces situations in which he is tempted to smoke but successfully avoids smoking, using methods described in the filmstrip.

Heart Risk Factors: Staying Well

This filmstrip describes the circulatory system in simple terms and the risk factors that affect it. Health measures for which a person must take responsibilities are described and presented as an important way to maintain good health.

Like the 16 mm films, these filmstrips are available for one-week loans. To order them, write to the Communications Division, WPS, P.O. Box 8190, Madison, WI 53708. Indicate your first and second choices of dates for viewing. If there is a scheduling conflict, WPS staff will contact you to arrange another date.

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

The Wisconsin Veterans Home has an immediate vacancy for a staff physician. Institutional geriatric practice at 700-bed state-operated Veterans Home. Located in an excellent summer and winter recreational area, the Wisconsin Veterans Home offers a challenging medical opportunity with the additional benefits associated with small community living. We offer competitive salary (starting to $63,000); liberal fringe benefits (40% fringe); regular hours, paid malpractice insurance, and other benefits. Contact: John Peters, Personnel Manager, Wisconsin Veterans Home, King, Wis 54946. An Equal Opportunity Employer. 3-7/80

Surgeon-General/Vascular, noncardiac chest. Position available with a 16-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, hospital, educational, civic advantages. Please call collect or write: B J Stoehr, MD or W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303. Phone: 414/494-5611. 4-7/80

Need two (2) Family Practice Physicians for a beautiful little community—almost completely drug and crimefree, good schools, close proximity to three colleges and one University of Wisconsin unit, good shopping, many cultural activities. Higher than usual compensation, early corporate inclusion, many fringe benefits. Well equipped 53-bed hospital, 60-bed nursing home, clinic, all under one roof. Regular consultative rounds by specialists from Madison and Dubuque. Active CME program. Five in group at present, average more than 15 years with group. Please contact: Dr M Stone, Cuba City Doctors Clinic, SC, Cuba City, Wis 53807. Phone: 608/744-2115. 5-7/80

Gonzalez Medical Center is seeking an Obstetrician/Gynecologist who is fluent in Spanish to join an established and successful practice. Minimum income guaranteed. Contact R Gonzalez, MD, 414/344-1120; 414/671-5410; and 414/476-8624. 5-7/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Federally qualified HMO needs Board certified/eligible family practice physician or internist to join primary care clinic with other FPs, internists, and pediatricians. Interest in OB is desirable. Experienced GP welcome. Team practice utilizes physician's assistants and nurse practitioners. Excellent salary and fringe benefit program. Location is State Capital and home of the University of Wisconsin. Teaching opportunities possible. Growing patient population of approximately 10,000 affords excellent opportunity. Contact Medical Director, Group Health Cooperative of South Central Wisconsin. 1 South Park St, Madison, Wisconsin 53715. Phone 608/257-9700. An equal opportunity employer. 6-7/80

Anesthesiologist wanted to join the Central Wisconsin Anesthesiology, SC, which consists of three established, hospital-based anesthesiologists. All specialties are served including open heart, neuro, obstetrics & gynecology. If interested phone 715/845-5505 or write to: Central Wisconsin Anesthesiology, SC, 425 Pine Ridge Blvd, Suite 207, Wausau, Wis 54401. 7-9/80

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 20-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 7tfn/80

Obstetrician-Gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Phone: 414/543-9580. 7/80

General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

OBSTETRICIANS-GYNECOLOGISTS WANTED

Obstetricians-Gynecologists board certified or eligible wanted to join in practice with obstetrician-gynecologist in a city of 100,000 on Lake Michigan between Milwaukee and Chicago. Excellent schools, medical school affiliation, security of freedom of practice in independent small group. Contact: Elizabeth A Steffen, MD, 734 Lake Ave, Racine, Wis 53404. Phone: 414/637-8311. 6tfn/80

Physicians Exchange

continued

Multispecialty Group of 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist
- Psychiatrist
- Dermatologist
- Family Practitioner

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. No personal investment. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

Internist wanted for half-time position: to work in the Geriatric Outpatient Clinic at Family Hospital in Milwaukee. The clinic is located in a newly remodeled 5000 sq ft facility and is part of the larger WRGC, an affiliate of Mount Sinai Medical Center. The physician will have his/her own panel of patients, have flexible hours, but no call responsibilities. He/she will work in a multidisciplinary team of social workers, geriatric nurse practitioners, and therapists. Send CV or call Robert W Timberlake, Administrator, Communications and Development, Family Hospital, 2711 West Wells, Milwaukee, Wis 53208. Tel: 414/344-9400, ext 225. 7-8/80

Wisconsin, Oshkosh: Career Emergency Physician with residency training and/or experience as emergency physician. Well-established fee-for-service corporation. Active community hospital with brand new physical facilities. Excellent staff backup, paramedic program, telemetry, flexible scheduling, competitive salary. Fringes: funded CME, generous health and disability insurance allowance, corporate-paid retirement plan, one month vacation, paid malpractice. ACLS certification required. Send complete CV: T M Loescher, MD, 2520 Crestview Dr, Appleton, Wis 54911. 7-9/80

Internist, Board certified or eligible, wanted to join busy primary care general internist; downtown Milwaukee, fringe benefits, salary open, partnership after short time. Contact Dept 480 in care of the Journal. p7/80

Family Practice, Hales Corners, Wis—to join 3 physicians in established practice. Board eligible/certified family physician or general practitioner, OB experience preferred. Guaranteed salary, paid professional liability insurance, opportunity for future partnership. Send your curriculum vitae to Whitnall Family Practice, 6080 South 108 Street, Hales Corners, Wis 53130 or call 414/425-5566 p7-9/80

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- Hematology/Oncology

Perfect location for good family living, 45 minutes from Madison and 90 minutes from Milwaukee. For details contact Robert E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566. Phone collect: 608/328-7000. 6-8/80

Internist—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

Family Physician—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

Wanted: General Surgeon needed to join group of three Board Certified Family Practitioners. Present surgeon in group retiring after 24 years of excellent established practice. Cumberland is a lovely city of 2000 surrounded by lakes. Six-man clinic adjacent to remodeled 47-bed hospital and new surgical suite. Minneapolis, St. Paul, and Eau Claire each 80 miles away. Contract negotiable. Corporate member in one year. Contact D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 5-7/80

Board Certified or Eligible Pediatricians for full or part-time positions in teaching hospital and medical school affiliated community ambulatory care center. Appointees will work as members of existing primary care group of faculty pediatricians and internists. Positions immediately available, starting date flexible. Faculty appointment in the Department of Pediatricis, Medical College of Wisconsin. Competitive salary and fringe benefits. Wisconsin licensure required. Contact G A Limbeck, MD, Director, Department of Pediatrics, Milwaukee County Medical Complex, Box 148, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-6392 (collect). p6-8/80

Seeking Full-Time Emergency Room physician. Southeastern Wisconsin. Contact John M Larsen, MD, Emergency Room Associates, Kenosha Memorial Hospital, Kenosha, Wis 53140. 7-8/80

Indiana—Fort Wayne: Emergency physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc, 4400 Broadway, Suite 306, Kansas City, Missouri 64111, 816/931-3040. 7-9/80

GP or FP wanted to take over my practice while on leave for two years. Well-equipped, 2-man medical facility, near 55-bed hospital, 80-bed nursing home attached. Trade area 15,000. Good schools, churches, rural, good hunting and fishing nearby. Reply with CV to Dept 479 in care of the Journal. 7-9/80

Family Physician: Appleton, Wis, to join 4 certified ABFP physicians. City of 60,000 - economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact: K E Buchanan, MD, 620 Longview Dr, Appleton, Wis 54911 or phone: 414/734-7144. 6-8/80

Board certified general surgeon desires to relocate in Wisconsin near large city. Wisconsin license. Willing to do some general practice. References upon request. Contact Dept 481 in care of the Journal. 7-11/80

Wanted—Family Physician to associate with four family physicians and two general surgeons to work in a satellite clinic with another family physician. 12 miles from Fond du Lac, Wisconsin, a community of 37,000 located on Lake Winnebago in the heart of Wisconsin's agricultural and recreational area. 60 miles from Milwaukee, Green Bay, Madison. Rotation of night and week-end call with four family physicians. 300-bed hospital. Excellent schools, four-year liberal arts college, two-year University of Wisconsin extension. Contact: John U Peters, MD, 505 East Division St, Fond du Lac, Wis 54935. Call collect 414/922-3700 (business) or 414/922-7899 (home). 4-7/80

Pediatrician—To join 5-man department in a multispecialty clinic, practicing general and consultative pediatrics. Northeastern Wisconsin community of 50,000 with referral base 100,000, excellent medical facilities; referral Intensive Care Nursery; progressive lakeside community. Contact G D Reilly, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Tel: 414/725-7071. 2-7/80

Wanted. Board Certified or Eligible OB/GYN; immediate opening with 8 physicians; multispecialty group of 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon. Clinic building is next to community hospital; expanding service area in western Milwaukee metro fringe location; first-year salary with optional second-year corporate stockholder; excellent fringe benefits including pension and profit-sharing plans. Contact J L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone 414/673-5745 collect. 5tfn/80

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Family Practice
- Cardiology
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Obstetrician-Gynecologist desired as an associate in a well-established solo OB-GYN practice in city of Milwaukee. Generous terms and guaranteed first year salary. Write Mohammad Shafi, MD, SC, 606 West Wisconsin Ave, Milwaukee 53203 or call collect 414/276-7632. 7/80*

Madison Clinic desires part-time internist or family physician (3rd year resident okay) to consult on integrative treatment regimen. Growth opportunity. Send CV and letter to Dept 482 in care of the Journal. 7/80

Medical Facilities

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For Sale: Excellent condition, retired from practice, make an offer. Bio Dynamic 1 bmc; 1 select-a-fuge 24; 1 unimeter 300; 1 Burdick EK III dual speed electrocardiography. Tel: 715/275-3785, 9am-10am or Dee W Bailey, RR 1, Box 156, Elcho, Wis 54428. p7/80

Allergy and Internal Medicine practice for sale. Immediate occupancy. Milwaukee location. Tel 414/464-4460 or 414/353-6645. 6-7/80

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Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of poblication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

WISCONSIN—1980

AUGUST 20-22: *Primary Care in Office Practice* conference presented by Ravenswood Hospital Medical Center, Chicago, at Interlaken Lodge & Villas, Lake Geneva, Wisconsin. See further details in ad on page 52 of this issue.

AUGUST 25-27: *Pediatric Applications of Evoked Potentials* at The Wisconsin Center, Madison. Fee: $200. 17 hours credit Category I of AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

SEPTEMBER 11-13: Wisconsin Society of Internal Medicine and American College of Physicians-Wisconsin Annual Meeting. Devil's Head Resort, Merrimac. Info: Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee 53202. (Further details appear in box in this section)

SEPTEMBER 12-13: Wisconsin Surgical Society fall meeting, Lake Geneva.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Toll free number 1-800/362-9080.

SEPTEMBER 17, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

SEPTEMBER 24-27: *The Fifth Annual Nuclear Cardiology Symposium.* The Red Carpet Inn, Milwaukee. Sponsored by the University of Wisconsin-Extension, Department of Continuing Medical Education, Cardiovascular Disease Program, Milwaukee Clinical Campus, University of Wisconsin-Madison, School of Medicine, American Heart Association—Wisconsin Affiliate, and Society of Nuclear Medicine. Fee: Mini Symposium (Sept 24), $40/physicians; $18/technologists. Conference fee (Sept 25-27), $220/physicians; $85/technologists; $250/1 physician/1 technologist team. 16 credit hours AMA Category I. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

OCTOBER 3-5: Midwest Allergy Forum, sponsored by Wisconsin Allergy Society. Hyatt Regency Hotel, Milwaukee. Info: Morton Soifer, MD, 707 W Glencoe Pl, Bayside, Wis 53217.

OCTOBER 15, 1980: *One-Day Seminar for Family Physicians,* St Vincent Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

OCTOBER 15-17: *The Sociopath 1980: A Practical Inquiry,* symposium and workshop addressing the problems of the community, the cop, the court, the classroom, and the clinician. Sponsored by the University of Wisconsin and the Mendota Mental Health Institute. Info: Bernadine Eve Bednarz, MSW (phone 608/263-4431) or write UW-Extension, 414 Lowell Hall, 610 Langdon St, Madison, Wis 53706.

OCTOBER 17-18: Wisconsin ACEP/EDNA Fall Symposium at Hyatt Regency, Milwaukee, ACEP member fee $125, nonmembers $150. 12 hours CME. Info: G L Gerschke, MD, 2025 E Newport Ave, Milwaukee 53211 or 414/961-3507.

OCTOBER 24-25: *Orthopedics for the Practicing Physician.* Wisconsin Center, and University of Wisconsin Clinical Science Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education, and University of Wisconsin-Madison, School of Medicine, Department of Orthopedic Surgery. Fee: $125. AMA Category I credit hours applied for. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 5-7: *Aging and Illness in Primary Care—Basic and Clinical Science Foundations.* Wisconsin Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and University of Wisconsin-Madison, School of Medicine, Departments of Medicine and Family Medicine and Practice. Fee: $215. 21 credit hours Category I of AMA; AAFP credit. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 7: Wisconsin Orthopedic Society meeting, starting at 9:00 am, Olympia Princess, Scottsdale Resort, Oconomowoc.

NOVEMBER 6-8: *2nd Annual Respiratory Critical Care Symposium: Acute Respiratory Failure—Admissions to Discharge.* The Inn on the Park, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and the University of Wisconsin Center for Health Sciences. Fee: $150/physician; $100/nurse, resident, allied health professional. 15 credit hours of Category I of AMA and Family Physician credit applied for. 1.5 CEU units. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 12, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

ILLINOIS—1980

SEPTEMBER 5-6: Illinois Congress on Continuing Medical Education, at Oak Brook Hyatt House, Oak Brook, Illinois. Theme: *Does CME improve physician performance?* This particularly urgent question is being addressed because the effectiveness of traditional CME is increasingly being questioned. In response to interest expressed by people from other states, CME planners from outside Illinois are being invited to this year's Illinois Congress. The theme of the Congress will be addressed directly by the speakers at two plenary sessions—Ronald W Richards, PhD, Director and Professor, Center for Educational Development, University of Illinois College of Medicine; and Richard M Caplan, MD, Associate Dean/CME at the University of Iowa. For additional information write or call the Illinois Council on CME at 55 East Monroe, Suite 3510, Chicago, Illinois 60603; (312) 236-6110. The Illinois Council on Continuing Medical Education was established in 1972 jointly by the Illinois State Medical Society and the state's eight medical schools and is supported primarily by contributions from ISMS members.

NOVEMBER 2-7: Annual Meeting, American Academy of Ophthalmology, McCormick Place, Chicago, Illinois. (Relocated from New Orleans to accommodate increasing attendance.) Info: AAO, 1833 Fillmore St, PO Box 7424, San Francisco, CA 94120, or call 415/921-4700.

ILLINOIS—1981

MARCH 2-6, 1981: Seventieth Annual Meeting of the United States-Canadian Division of the International Academy of Pathology, at the Palmer House, Chicago, Illinois. The Maude Abbott Lecture entitled "The Impact on Time on the Diagnosis and Treatment of Cancer: 1936-1981," will be delivered by Dr Lauren V Ackerman on March 3. Scientific papers, poster sessions, twelve specialty conferences, and 50 short courses are scheduled. A special course will be offered on "Immunopathologic Techniques in Diagnostic Pathology," with Dr Robert T McCluskey as course director. The long course will be on "The Inflammatory Process and Infectious Disease," with Doctors Guido Majno and Ramzi Cotran, course directors. Further info: Dr Nathan Kaufman, Secretary-Treasurer, United States-Canadian Division of the IAP, 1003 Chafee Avenue, Augusta, Ga 30904; telephone: 404/724-2973. g7-12/80

OTHERS—1980

AUGUST 20-22: Consensus Development Conference: "Endoscopy: What is Its Role in Upper Gastrointestinal Bleeding?", at Masur Auditorium, National Institutes of Health, Bethesda, Md. Sponsored by the Digestive Diseases and Nutrition Program of the National Institute of Arthritis, Metabolism, and Digestive Diseases. For practicing physicians and experts in relevant fields such as gastroenterology, liver diseases, endoscopy, radiology, and biostatistics. Info: Mrs Billie B Mackey, Digestive Diseases and Nutrition Pro-

1980 WSIM/ACP Annual Meeting Program

September 11-13, 1980
Devil's Head Resort - Merrimac

Sept 11: Tennis and Golf Tournament, Registration desk opens at 4:00 pm.

Sept 12: Welcome and Introductory remarks, *Michael J Mally, MD,* Hartford, President, WSIM; *Charles L Junkerman, MD,* Milwaukee, American College of Physicians, Governor for Wisconsin

Michael W Rytel, MD, FACP, Milwaukee, Program Moderator

New Treatment for Lower Respiratory Tract Infections, *Robert E Van Scoy, MD,* Dept of Medicine, Mayo Clinic Graduate School of Medicine

Antibiotics In Vivo and In Vitro: Why Some Antibiotics Don't Work in Your Patient, *Leon D Sabath, MD, FACP,* Dept of Medicine, University of Minnesota School of Medicine

Manipulation of the Cephalosporins for the Future, *Martin J Raff, MD, FACP,* Dept of Medicine, University of Louisville School of Medicine

Prophylactic Antibiotic Therapy, *Dennis G Maki, MD, FACP,* Dept of Medicine, University of Wisconsin School of Medicine

The Middleton Memorial Lecture - Dementia, *Jeremiah A Barondess, MD, MACP,* Past President ACP

Myasthenia Gravis and Myasthenic Syndrome, *Frank M Howard Jr, MD,* Dept of Neurology Mayo Clinic, Mayo Graduate School of Medicine

Inflammatory Myopathies, *David B Frens, MD,* Dept of Neurology, Marshfield Clinic

Polyradiculopathies, *James W Alberts, MD,* Dept of Neurology, University of Michigan School of Medicine

Sept 13: Breakfast and Business Meeting

Socio-Economic Program; Prepaid Health Care: The Pros and Cons, *Russell A Quirk, MD,* Racine, Moderator; *Mervin Shalowitz, MD,* Skokie, Ill, Speaker; *Russell F Lewis, MD,* Marshfield, Speaker

INFO: Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee 53202.

gram, National Institute of Arthritis, Metabolism, and Digestive Diseases, Building 31, Room 9A21, Bethesda, Md 20205 (301/496-6158).

SEPTEMBER 15-18: *American College of Emergency Physicians.* Las Vegas, Nev. Contact: Communications Group, ACEP, 3900 Capital City Blvd, Lansing, Mich 48906.

SEPTEMBER 29-30: *National Conference on Patient's Rights,* sponsored by the American Society of Law & Medicine, at the Opryland Hotel in Nashville, Tennessee. Open to physicians, nurses, hosptial administrators, patient advocates, attorneys, social workers, philosophers, ethicists, chaplains, risk manager, and others interested in the growing movement to recognize and implement the rights of healthcare consumers. The 1970s saw the birth of the patient rights movement as an outgrowth of the civil rights movement and the malpractice crisis. This conference addresses the concept and context that patient rights will take in the 1980s, as the rights won in the 1970s are implemented. Distinguished faculty of nationally prominent experts includes:

- **George J Annas, JD, MPH,** Conference Chairperson, Associate Professor of Law & Medicine, Boston University Schools of Public Health and Medicine, and author, *The Rights of Hospital Patients;*
- **G Gordon Bonneyman, JD,** Legal Services of Middle Tennessee, Inc, Nashville;
- **Kathleen M Countryman,** Coordinator of Patient Relations, University of Minnesota Hospitals & Clinics, Minneapolis;
- **Leonard H Glantz, JD,** Assistant Professor of Law & Medicine, Boston University Schools of Medicine and Public Health;
- **Jay Hedgepath, JD,** General Counsel, American Hospital Association;
- **Jane A Boyajian Raible, D Min,** Humanities Scholar, Washington State Legislature;
- **Robert N Brown, JD,** College of Law, University of Detroit;
- **County Gibson, MD,** Chairman, Department of Community Medicine, Stanford Medical School, Palo Alto, Calif;
- **Doris B Haire,** President, American Foundation of Maternal and Child Health, New York City;
- **Angela Holder, JD, LLM,** Counsel for Medicolegal Affairs, Yale-New Haven Medical Center;
- **John A Robertson, JD,** Visiting Professor of Law, University of Texas, Austin; and
- **Robert M Veatch, PhD,** Professor of Medical Ethics, Kennedy Institute of Ethics, Georgetown University.

Registration fee: $125 for members of the ASLM and $145 for nonmembers; includes a volume of conference materials and luncheons on both days. Advance registration required. To register, send name, address, and registration fee to: Conference Registrar, ASLM, 520 Commonwealth Ave, Boston, Mass 02215. g7-8/80

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION

REGISTER NOW FOR THE 65th **Interstate Postgraduate Medical Association Scientific Assembly**

MGM Grand Hotel • Las Vegas, Nev.

November 3-6, 1980

Program planned under the direction of Alton Ochsner, MD, New Orleans, La, and in cooperation with the Nevada Academy of Family Physicians and the University of Nevada School of Medical Sciences

This prestigious annual educational conference offers . . . for only $125 . . .

- 24 hours prescribed credit, 4 elective hours AAFP
- 24 hours Category 1 credit, 4 hours credit in Category 5(a), PRA-AMA
- Program objective to update clinical knowledge in the diagnosis and treatment of the commonly occurring problems in cardiology, endocrinology, gastroenterology, prospective medicine, geriatrics, rheumatology, orthopedics, and nuclear medicine
- Special events and tours

For registration materials and program, return the form below to Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701

Name _____

Address _____

City _____

State _____ Zip _____

SEPTEMBER 29-OCTOBER 1: NIH Consensus Development Conference on CEA (Carcino-Embryonic Antigen): Its Role as a Marker in the Management of Cancer, sponsored by the National Cancer Institute, National Institutes of Health, to discuss: • Can CEA be used in screening for cancer? • Is CEA helpful in the diagnosis of cancer? • What does CEA tell us about the extent and outcome of cancer? • Can the CEA assay be improved? • Can CEA be used in combination with other markers? To be held at Masur Auditorium, Clinical Center (Building 10), National Institutes of Health, Bethesda, Md. For technical information contact: Dr K Robert McIntire, Chief, Diagnosis Branch, Division of Cancer Biology and Diagnosis, National Cancer Institute, Building 31, Room 3A10, Bethesda, Md 20205; phone 301/496-1591. For administrative information contact: Ms Yvonne Lewis, Prospect Associates, 11325 Seven Locks Road, Suite 220, Potomac, Md 20854; phone 301/983-0535. Preregistration will be requested.

OCTOBER 9: *Hypertension in Family Practice: Evolving Concepts.* The Rivergate Exhibition Center, No 4 Canal St, New Orleans, LA. This symposium has been accepted as a special presentation immediately following the Annual Meeting of the American Academy of Family Physicians. Info: World Health Information Services, Inc, 475 Fifth Ave, Suite 505, New York, NY 10017. Phone: 212/679-6200. p7-8/80

OCTOBER 19-24: *American Academy of Physical Medicine and Rehabilitation,* Washington, DC. Contact: Barry Miller, PO Box 995, Ann Arbor, Mich 48106, 313/572-3562.

OCTOBER 19-24: *Annual Clinical Congress, American College of Surgeons,* Atlanta, Georgia. Info: ACS, 55 East Erie St, Chicago, Ill 60611; (312) 644-4050, ext 324.

OCTOBER 24-26: *American Academy of Neurological and Orthopaedic Surgeons.* Contact: Michael R Rask, Program Chairman, 2320 Rancho Drive, Suite 108, Las Vegas, Nev 89102.

OCTOBER 26-30: Annual Scientific Assembly of the American College of Chest Physicians, at the Sheraton Boston Hotel and Hynes Auditorium Convention Center, Boston, Mass. *CAT Scanning—Cardiopulmonary Disease* and *Detection, Diagnosis, and Management of Lung Cancer* are two of the six subjects to be discussed in the major symposia sessions. Full-day programs discussing such topics as occupational lung disease, critical care, perfusion technology, respiratory care, and echocardiography will be presented. Over 30 hours of credit may be obtained toward Category I of the PRA-AMA. Further info: Dale E Braddy, Director of Education, ACCP, 911 Busse Highway, Park Ridge, Ill 60068.

NOVEMBER 3-6: 65th Annual Scientific Assembly of Interstate Postgraduate Medical Association at the MGM Grand Hotel, Las Vegas, Nev. Info: Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701. g7-9/80

DECEMBER 6-11: American Academy of Dermatology, New York, NY. Info: AAD, Inc, 820 Davis St, Evanston, Ill 60201 (Phone 312/869-3954).

AMA—1980

SEPTEMBER 12-13: *AMA Seminar on Knowledge and Skill Development in Negotiations,* Kansas City, Mo. Introductory seminar for physician negotiators: *Dynamics of Conflict Resolution with Health Planning and Other Government Agencies.* Radisson-Muehlebach Hotel. As an organization accredited for continuing medical education, the AMA Council on Continuing Physician Education certifies that the continuing medical education activities designated Category I meet the criteria for Category I on an hour-for-hour basis for the Physician's Recognition Award of the American Medical Association. For more information contact AMA Department of Negotiations, 535 North Dearborn St, Chicago, Illinois 60610, or call 312/751-6652.

DECEMBER 7-10: Interim AMA House of Delegates, San Francisco Hilton, San Francisco, Calif.

AMA—1981

FEBRUARY 12-15: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9: Interim AMA House of Delegates, Las Vegas Hilton, Las Vegas, Nev.

AMA—1982

FEBRUARY 25-28: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8: Interim AMA House of Delegates, Fountainbleu Hilton, Miami, Fla.

CHILDREN AND TEENS brochure that addresses talking book and braille reading services for children and teenagers who are visually or physically handicapped. Bulk copies of this brochure are available for distribution to patients. For copies write to: Publication Services, National Library Service for the Blind and Physically Handicapped, The Library of Congress, Washington, DC 20542.

SEMINARS IN PEDIATRICS

October 9-11, 1980

Concourse Hotel and University of Wisconsin Clinical Science Center, Madison, Wisconsin

Presented by the University of Wisconsin-Madison, School of Medicine, Department of Pediatrics and University of Wisconsin-Extension, Department of Continuing Medical Education, Madison.

Seminar is open to Pediatricians, Family Practitioners, and General Practitioners and qualifies for 15 hours of Category I of the AMA-PRA and AAFP.

Fee: $200

Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

INFANT FEEDING

THE PUBLIC HEALTH Nutrition Program of the Wisconsin Division of Health, Department of Health and Social Services, has developed new materials on infant feeding for distribution to parents and caretakers of infants and toddlers. The new material is in the form of a series of 11 leaflets, each dealing with a single topic on feeding the very young child. These are:

- —Breast Feeding
- —Commercial Formula Feeding
- —Bottling
- —Weaning
- —Introducing Solid Foods
- —Feeding Babies: The Commercial Way
- —Vegetarianism: Diet for a Little World
- —Feeding Problems
- —Feeding Your Toddler: Diet After the First Year
- —Homemade Baby Foods
- —Teething

Quantities of these leaflets are available to physicians for distribution to their patients. Contact Division of Health, PO Box 309, Madison, Wis 53701; or phone (608) 266-1511.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

MINORS MAY CONSENT FOR CERTAIN ALCOHOL AND DRUG ABUSE TREATMENT. Beginning July 1 physicians or healthcare facilities may render certain preventive, diagnostic, assessment, evaluation or treatment services for drug or alcohol abuse to minors, 12 years of age or over, without obtaining the consent of or notifying the minor's parent or guardian. However, the new law also requires that the minor's parents or guardian "shall" be notified of any services so provided "as soon as practicable." This provision was contained in Assembly Bill 742 which passed in the final days of the legislative session, and became Chapter 331, Laws of 1979. Parental consent is still required in the following instances: a) before performing surgery on the minor, unless the procedure is essential to preserve the minor's life or health and parental consent is not readily obtainable; b) before administering controlled substances, except for purposes of detoxification; c) before admitting a minor to an outpatient treatment facility, unless the admission is for detoxification; and d) if the period of detoxification extends beyond 72 hours after the minor's admission as a patient to a treatment facility.

Physicians or healthcare facilities shall obtain the minor's consent prior to billing a third party for services provided under this law. If the minor does not consent, the minor is responsible for paying for the services. In cases where physicians or healthcare facilities are contracted to provide services under s. 51.42 boards, the boards will pay for services rendered under the law. Parents are not responsible for payment where consent for treatment was not given. No physician or healthcare facility rendering services under this act is liable solely because of the lack of parental consent or notification. SMS and other authorities are seeking further clarification of the consent and notification provisions of the law.

GASTRIC BYPASS AND THE T-19 PROGRAM. The Wisconsin Department of Health and Social Services is redefining its recent decision to prohibit payment for gastric bypass operations in the Medicaid (T-19) program. On April 14, DHSS announced a three-year "moratorium" on payment for the procedure when used for weight control or reduction. Following protests from several corners including SMS, DHSS has now indicated that the moratorium will *not* be implemented, although prior authorization is necessary for gastric bypass surgery.

However, relative to *gastroplasty-stapling,* the DHSS has chosen *not* to authorize payment for this procedure when done for obesity because of a lack of favorable clinical experience. The DHSS designates this procedure as "experimental."

During the next three years, the DHSS anticipates that specific criteria regarding the technical aspects of gastroplasty-stapling will be perfected and that its possible designation as a covered service will then be reviewed. DHSS statistics suggest that nearly 20 percent of all gastric procedures done for obesity are performed on Medicaid recipients.

Since the DHSS has not yet formally defined the limits of gastroplasty-stapling and the effective dates of the moratorium, physicians are again urged to watch for future developments in MEDIGRAM and the WMJ's NEWS YOU CAN USE column.

INTEREST PAID ON UNPAID CLAIMS. Wisconsin law provides that a person, including a physician collecting on behalf of a patient, is entitled to have an insurance claim paid promptly after filing a claim for a covered service. The law also states that physicians and others may charge simple interest at the rate of 12 percent a year on a claim on which payment is overdue. A claim is overdue if not paid within 30 days after the insurance carrier receives written notice of the covered loss and the amount of the loss. The 30-day rule also applies to partial claims submitted to the carrier. A payment is not overdue when the insurance carrier has "reasonable proof" to establish that the carrier is not responsible for the payment even though written notice of the claim has been submitted, or where there is a good faith question as to the services or charge. ■

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WISCONSIN MEDICAL JOURNAL

AUGUST 1980

• Medicine's role??? • The Wisconsin Physician's Assistant • Radionuclide patterns in pediatric hip pain • Council adopts protocol for mediation, peer review • SMS committee to study care of chronically mentally ill • Major reform for public health system proposed • AMA annual convention highlights

Now, two dosage forms

Nalfon®
fenoprofen calcium

300-mg.* Pulvules® and 600-mg.* Tablets

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. and 691.8 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. and 600 mg. fenoprofen respectively.

700934

MDSG #8
Jul. 79

LIBRARY OF THE
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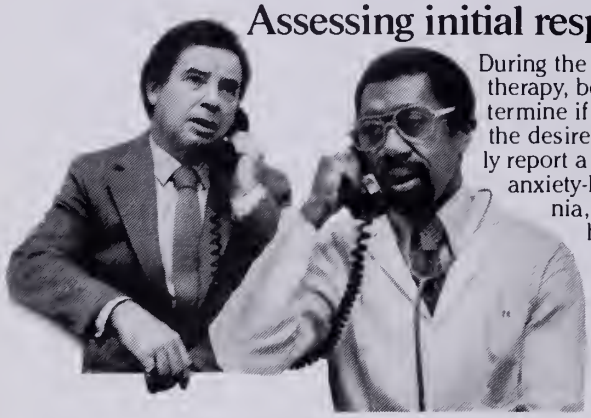
OF PHILADELPHIA
SEP 10 1980

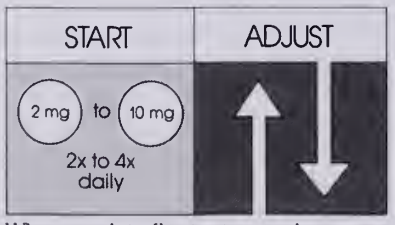
Monitoring patient response to Valium® (diazepam/Roche)



Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.

Making dosage adjustments



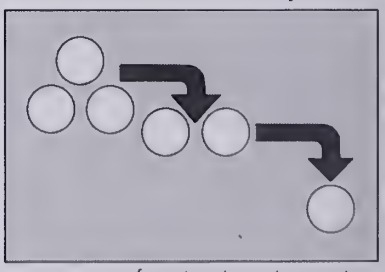
With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dos is good medical prac Although rarely necessary after short-ter treatment with Valiu gradual dosage reduc is advisable for patie who have been on ex tended therapy. This ual discontinuance should preclude eith recurrence of pretreatment symptoms or development of toward side effects. Symptoms of withdrawal have almost ways been associated with abrupt discontinuance of thera higher dosages taken continuously over long periods of ti

2-mg, 5-mg, 10-mg scored tablets

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diazepam/Roche

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ROCHE®

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Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d. alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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THE STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841 . . . Representing nearly 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections, with all members belonging to the American Medical Association. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's Page

Russell F Lewis, MD

Medicine's role???

TRADITIONALLY the role of medicine has been to take care of sick people—diagnosis, treatment, and prevention. In recent years, with changing attitudes and philosophies, many have questioned whether this role is adequate. In 1970 when the term Health Maintenance Organization (HMO) became a popular one, the word "maintenance" became a byword used particularly by the media and health administrators to indicate an area that physicians traditionally had neglected. They contended we had limited our role to taking care of sick people. Those of us involved early in the HMO movement realized that preventive medicine, as we knew it, had been pretty much limited to immunizations, screening programs, and public health measures. It became apparent that individual life style is the major factor in maintaining good health. My concern is that medicine is not making a decision as to what our role is in this process. During this time, in the United States, society continues to move from centralized control to local control. Individual involvement with a specific movement or cause is becoming a way of life. We have rediscovered health maintenance. It is an idea whose time suddenly has come, at least in the eyes of its promoters.

At the same time we are going through an era of rapidly increasing use of allied health providers, both in numbers and types. Some of these assume roles at our direction in the patient education field. We now have active movements in preventive medicine, in wellness, patient education, screening and health appraisal, and self-care.

I have just read a series of articles by the National Chamber of Commerce attempting to teach business how to promote good health for its employees and their families—health promotion. Government in recent years has borne a major role in financing healthcare. Increasingly businesses, through employee health insurance plans, have found that they are picking up a major portion of healthcare costs. They have also discovered that while their insurance expenses are great, the cost to their companies as a result of employee absenteeism, or inefficiency, is three to four times as expensive as their insurance programs. Today major employers, finding that they can no longer afford not to be involved in healthcare, are becoming interested in the so-called "health promotion movement" which, in essence, encompasses all the programs already mentioned. What is medicine's role in relationship to these employers and their healthcare problems, particularly as to cost?

Of note is the fact that the Council of the Society, through an ad hoc committee, recently completed an in-depth study of public health in Wisconsin. This study with recommendations was presented to Governor Dreyfus. Among other issues, it calls for the development of "strategies for effective health promotion and illness prevention" through a "meaningful public and private partnership." This recommendation is, I think, on the right track.

Medicine is going to have to make a major decision soon as to whether we want to continue our perceived role of taking care of sick people, working with proponents of some of these new programs to the best of our ability as the need arises, or whether we should attempt to become leaders in integral parts of these new movements. In small communities much of this is happening already. However, the public does not perceive us as representing leadership in these movements. The physicians' authority is being questioned, and their leadership role is being taken over by aggressive individuals championing a cause. Unfortunately, in some instances, medicine's traditional approach is downgraded. It has always been my belief that the major problem confronting organized medicine is that most doctors are too busy practicing medicine to get involved with the socioeconomic and other issues which are becoming increasingly important in today's society. I believe medicine has an obligation as the most knowledgable body to speak out and give sound direction to many of these issues. It seems important to me that we decide that our role is to get involved and then make a sincere effort to become more active in this direction to everybody's benefit. ■

Editorials

Editorial Director: WAYNE J BOULANGER, MD

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

See no evil

A LETTER dated June 11, 1980 under the heading CORRESPONDENCE/MEMORANDUM was received by Ronald J De Lain, County Clerk, Brown County, Green Bay, Wisconsin. The letter was from R D Nashold,* State Registrar, and the subject was Antenuptial Physical Examination (ss 765.06).

The subject of the letter, abstracted, is "We have received complaints that . . . . . ., couples about to apply for a marriage license are given a complete physical by the physician, rather than a physical examination for the detection of venereal disease."

The letter was forwarded to the President of the Brown County Medical Society in order that he acquaint the member physicians with the nature of the complaint and that they somehow be less investigative of venereal disease. The letter further stated "that the legal counsel for the Wisconsin Department of Health and Social Services advises that the practice of giving complete physicals could be challenged if the physician represents that such examination is mandatory as part of the statutory requirement." Further, "it is possible that the county medical society might refer the matter to the State Medical Examining Board to determine what action would be needed to bring this practice to an end." And also, ". . . at the present time, there is no requirement for a complete physical examination prior to the issuance of a marriage license."

The PHYSICIAN'S CERTIFICATE which is necessary to obtain a marriage license and is signed by the physician states that "I, being a physician, legally licensed to practice in the State of Wisconsin, do certify that I have on (date) made a *thorough* examination for and believe such persons to be free from all venereal disease; and I do certify that such person was given the Wasserman or other standard test for syphilis at (name of laboratory) from blood taken by (name of technologist) on (date) and the result of such test was negative." (Emphasis added by author) This is followed by the date and the signature of the physician performing the examination and his post office address.

*Mr Nashold also is director, Bureau of Health Statistics, State Division of Health, Department of Health & Social Services.

Apparently, the complaint is that the doctors are too thorough. The applicants for the "antenuptial" physical examination think that any examination that includes more than the external genitalia violates the statute or their civil rights.

Every physician knows that syphilis is the "great imitator" and it can be manifested as a skin disease or may first be noted on the oral mucosa, perhaps as a neurologic finding or even in an altered aortic second sound on auscultation. The widely known complications of CNS syphilis apparently cannot be examined for under Mr Nashold's directive.

But the certificate signed by the physician requires him to do a thorough examination. Does this include palpating the inguinal nodes for lymphogranuloma venereum? A proctoscopic for evidences of venereal disease? Is the entire process to be confined simply to a serologic evaluation of the patient without considering chancroid or Reiter's syndrome? With the sexual revolution of the last decade, there is scarcely an organ or system that could not be the presenting site of venereal infection. Is it the intention of the Department of Health and Social Services to ignore extragenital evidences of venereal disease?

And another thing: what is a CORRESPONDENCE/MEMORANDUM anyway?—RAMc

Alejandro R Guansing, MD: 1937-1980

WHEN Alejandro R Guansing, MD, died recently in Milwaukee at the age of 42, a promising career and hopeful medical-social program was cut short.

Doctor Guansing was not only a valuable practitioner of endocrinology at the Veterans Administration Hospital but he also was breaking new ground in the establishment of the Wisconsin Philippine Medical Association with plans to help his Philippine colleagues more rapidly enter the mainstream of medicine in this state. His determination and bright outlook for better things for his fellow physicians and their families did not obscure a higher goal of helping the medical profession become more united and able to better

serve the public. At the time of his death he was working closely with the county and state medical societies to build his dream.

Our sympathy goes to his family and many friends. We hope that others will seek to continue what he so hopefully began.—ERT

Manipulative dermatology

A WISCONSIN Doctor of Chiropractic recently wrote this in his column "Health Wise": "Many eczema patients have a rash on exactly the same areas on both sides of the body. In such cases, there is often a spinal misalignment in the upper part of the neck. Nerve irritations in this area, caused by a misalignment however slight, can cause a wide variety of symptoms including skin rashes. Removing nerve irritation caused by spinal misalignment is a function of chiropractic techniques. Frequently, it offers relief from the discomfort and disfiguration of eczema."

Can dermatologists adjust to this innovative therapy?—VSF ■

Bookshelf

New books received *are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.*

What You Should Know About Medical Lab Tests. By Bernard Kliman, MD, Ramond Vermette, and Ernest Kolowrat. Thomas Y Crowell Company, 10 East 53rd St, New York, NY 10022. 1979. Pp 207. Price: $9.95.

Chlorophyll Organization and Energy Transfer in Photosynthesis. Ciba Foundation Symposium 61. CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, NJ 97901. 1979. Pp 374.

Principles of Clinical Electrocardiography. 10th Edition. By M J Goldman, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1979. Pp 415. Price: $12.00.

Birth of a Family: The New Role of the Father in Childbirth. By Nathan Cabot Hale. Publicity Department, Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 208. Price: $7.95.

Rosenhaus Lecture 5th Annual, American Public Health Association, 1015 Eighteenth St, NW, Washington, DC 20036. 1977.

Exile and Return: The Struggle for a Jewish Homeland, by Martin Gilbert. Lippincott Publishing Co, 521 5th Ave, New York, NY 10017. 1978. Pp 364. Price: $12.95.

Deliverance Day: The Last Hours at Dachau, by Michael Selzer, Lippincott Publishing Co, 521 5th Ave, New York, NY 10017. 1978. Pp 253. Price: $10.95. ■

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FWT-2D

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

MEB says WMJ article misleading

THE ARTICLE in your June *Blue Book* entitled "Physician and Hospital Records: Retention and Inspection" is misleading in that it slights sec. 146.82, Wisconsin Statutes which provides for access to patient records without informed consent.

Half of your article, approximately two pages, was devoted to discussing who can inspect medical records under what circumstances. The whole thrust of this section on inspection and copying of records was authorization. This focus is very misleading because sec. 146.82, Wis. Stats., provides for inspection of records without authorization.

One of the Medical Examining Board's most serious hurdles is gathering medical records. Often medical records are the most crucial evidence needed to substantiate or disprove allegations of unprofessional conduct. I fear that you have made our job of gathering evidence for disciplinary cases much more difficult by publishing two pages of material on inspection of records without even mentioning our right of access to medical records without informed consent. Instead of stressing authorization, to promote cooperation with the Medical Examining Board, stress should be placed on our right of access to records without authorization or informed consent.

Physicians who rely on your article will at least delay our investigations by trying to require us to provide authorizations when in fact this is not legally required. If a physician wants to protect him or herself from an investigation into the underlying facts to support an allegation of unprofessional conduct, that physician might try to invoke the patient's right to confidentiality.

We ask that you cooperate to the extent that you recognize publicly our right of access to medical records and not stress authorization to impede our attempts to protect the public from unprofessional conduct.

—**Mary Reddin**, *Secretary*
Medical Examining Board
Department of Regulation and Licensing
State of Wisconsin
Madison, Wisconsin

Editor's note: The law places a duty on physicians (and hospitals) to keep the records of patient treatment confidential. This "privilege" belongs to the patient and generally cannot be broken by the physician without the consent of the patient. Government agencies have access to records under certain circumstances and this is explained in the article. However, the main thrust of the article, which is published for physicians, is designed to tell them what must be done to conform to the laws of confidentiality and privilege, which are designed for the patient's benefit. ■

NEWS YOU CAN USE

INTRODUCTORY SEMINAR FOR PHYSICIAN MEDIATORS SCHEDULED FOR SEPTEMBER 12-13. The AMA Department of Negotiations has scheduled a two-day seminar for physician mediators at the Radisson-Muehlebach Hotel in Kansas City, Missouri, September 12-13. See further details in the YELLOW PAGES of this issue.

MODERNIZING OLD COMMERCIAL BUILDINGS GETS A NEW TAX INCENTIVE. In a recent issue of the *Wall Street Journal* the following information was reported; it may be of interest to physicians: "The 1978 Revenue Act granted investment tax credits for rehabilitating old business buildings after Oct 31, 1978. But it failed to set aside existing restrictions on investment credits for noncorporate lessors of property under long-term or net leases. The restrictions were aimed at tax shelters for equipment leasing, but they resulted in denying the 1978 rehabilitation incentives to individuals and partnerships. Now, however, the recent Technical Corrections Act lets noncorporate lessors qualify for the rehabilitation credit, too. That plus depreciation 'creates significant tax incentives for such projects,' says Arthur Andersen & Co. Moreover, the recent act makes both the regular investment credit and the energy credit available when the improvement qualifies as both. Thus, older commercial buildings become attractive tax shelters for partnerships." ■

Special

The Wisconsin Physician's Assistant

A WISCONSIN law was enacted in 1975 to authorize the physician's assistant (PA) to work under the supervision of a licensed physician. The law assigned responsibility for PA regulation to the State Medical Examining Board. A complete set of rules (Chapter Med. 8) was subsequently developed and is now in effect. The intent of this total effort has been to provide for the orderly, productive, and qualitative use of the PA.

There are presently 275 certified PAs in Wisconsin. The greatest percentage of them are serving in practices located in small cities and rural communities. Nationwide there are approximately 12,000 PAs working in all 50 states.

Emergence of the PA

Historically the concept of the physician's assistant (with the delegation of tasks) is long lived. Physician delegation of duties to nurses and medical assistants has occurred for decades. What is new is the development of formal training programs to prepare personnel to extend the physician's capabilities in the diagnostic and therapeutic management of patients.

The first formal PA training program began in 1965 at Duke University. Several additional programs emerged in the ensuing five years. Less than 200 PAs had been graduated nationally by 1971. These first formally trained PAs drew a public and professional response sufficient to spur passage of the Comprehensive Health Manpower Act of 1971 which funded additional PA training programs.

The American Medical Association has been deeply involved in the development of the PA concept from the very beginning. Its 1970 definition of a PA still stands today and reads as follows:

> "The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

In 1971 the AMA Council on Medical Education established the "Essentials of an Approved Education Program for the Assistant to the Primary Care Physician." These standards still guide the development and self evaluation of formal PA training programs.

Today these PA education programs are standardized and accredited by the Committee on Allied Health Education and Accreditation (CAHEA), an AMA-sponsored group. The Joint Review Committee (JRC) conducts on-site visits and makes recommendations to CAHEA.

Graduate PAs must pass a national certification examination from the National Commission on Certification of Physician's Assistants (NCCPA) in order to practice in most states. Continuing education requirements have been imposed by the NCCPA including 100 hours of continuing education every two years and a recertification exam every six years.

Training programs in Wisconsin

The late Dr Francis Lorenz of the Marshfield Clinic viewed the PA concept as one worthy of wide physician support in Wisconsin. He was an early and influential figure in the development of this state's first PA program, which was opened in 1972 by the Marshfield Medical Foundation.

The PA program at University of Wisconsin was established in 1975 and serves as an excellent model of an accredited program. Applicants must have a minimum of two years of college with specific care and science courses. Preference is given to applicants with patient contact experience sufficient to comprehend their role as dependent practitioners.

The Wisconsin program lasts for two years, consisting of equal parts of didactic coursework and supervised clinical preceptorships. At the completion of the program the graduate receives a bachelor of science degree from the School of Allied Health.

Laws and rules

The State Medical Examining Board is charged with regulation of PAs. The PA must list the name(s) of his supervising physician(s) at the time (s)he applies for certification. No physician may supervise more than two PAs.

Wisconsin law states that each applicant for certification as a PA must be a graduate of an AMA-approved program. The applicant must also show proof of having passed the NCCPA national examination. Temporary certification may be granted to graduates of approved programs until such time as they receive notice that they have passed the national exam. All PAs must reregister annually.

The Medical Examining Board rules lists a variety of patient services which can be provided by the PA. Although these are too numerous to include in entirety, they include initial patient evaluation, routine laboratory studies, routine therapeutic procedures, counseling, monitoring treatment plans, and facilitating referrals. Also included are institutional patient services such as surgical assisting, patient rounds, progress notes, etc.

Supervision is defined as "to coordinate, direct, and inspect continually and at first hand the accomplishments of another, or to oversee with powers of direction and decision the implementation of one's own or another's intentions."

A physician's assistant may practice on premises away from the main office of the supervising physician provided that supervision is maintained.

Another licensed physician may be designated to supervise a PA for periods not to exceed eight weeks per year.

Quality aspects

Better use of physician time and improved medical care are benefits usually cited from PA staffing. More time is noted as being available for the physician to address the more complex medical problems. Also, various studies indicate good patient acceptance of the PA.

Further investigations have demonstrated no significant difference in morbidity or outcome in primary care service delivered by the physician/PA team. Moreover, other informed sources have found no indication that incorporating a PA into a practice increases the likelihood of liability.

Cost of care

Several studies have projected that use of the PA can reduce medical cost by (a) maintaining and increasing productivity in lieu of raising patient care costs; (b) reducing the frequency of hospitalization by stressing preventive medicine; and (c) taking into account the reduced formal education costs of medical personnel.

Access to care

The current feeling is that the medical manpower problem is one of distribution with the great majority of physicians located in metropolitan areas. In contrast, a large percentage of PAs are located in rural communities where their presence enables the physician to extend quality care to more people.

Conclusion

It is important to emphasize that the PA is (1) assistant to and dependant on the employer physician with all formal education so directed; (2) trained to identify with physicians in modes of thought, patterns of action and reaction, and dedication to moral and ethical value systems, and (3) prepared to assume appropriate responsibility. There is no evidence to indicate that PAs wish to function as independent practitioners.

Studies support a belief that PAs can extend physician capabilities in delivery of care to rural and underserved areas without sacrificing quality or increasing cost.

Persons desiring further information about participating in the training of PAs employing a PA, or about the PA concept in general should contact: The Wisconsin Academy of Physician's Assistants, PO Box 1109, Madison, Wisconsin 53701. Executive Secretary: Bill Wendle, telephone 608/257-6781 or 800/362-9080 ■

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Cancer Column

Prepared and supported by the Wisconsin Clinical Cancer Center
in collaboration with the State Medical Society of Wisconsin

Bladder cancer—new approaches[1]

THE WISCONSIN Clinical Cancer Center is investigating strategies for inhibiting bladder carcinogenesis. The first method of intervention is to remove carcinogens from the environment; however, this has not been uniformly successful. People have been very reluctant to restrict their use of tobacco, cyclamates, and saccharin. Economic and political factors have made elimination of such known chemical carcinogens from the environment very difficult.

Secondly agents may be added to the environment in attempts to interfere with the development of bladder cancer. One way to do this is to interfere with the interaction of a carcinogen and its target tissue. For instance, bracken fern causes intestinal and bladder tumors in rats. Studies have shown that butylated hydroxyanisole (BHA), disulfiram, and calcium chloride decrease the incidence of intestinal tumors in rats fed bracken fern 25-30%, while polyvinylpyrrolidone (PVP) and calcium chloride inhibit bracken fern induced bladder carcinogenesis by about 80%.

Another possibility is to change the balance between activation and detoxification in favor of detoxification. Detoxification by microsomal enzyme systems may protect animals. Increased microsomal enzyme activity inhibits the carcinogenic effect of a number of chemical carcinogens, including polycyclic hydrocarbons, azo dyes, and 2-acetylaminofluorene. Dietary phenothiazine causes increased microsomal enzyme activity which may enhance the detoxification of the carcinogenic substances in bracken fern and decreases the incidence of both intestinal and urinary bladder tumorigenesis by about 60%.

To successfully detect bladder cancer early and follow its development, it is necessary to identify morphological and biochemical markers of the disease and develop models to use in planning treatment strategies for human bladder cancer. The majority of bladder cancer patients excrete elevated amounts of 7-methylguanine, pseudouridine, and β-aminoisobutyric acid in their urine. These markers, which are metabolic breakdown products of nucleic acids, are not clinically useful alone. However, excretion of polyamines such as putrescine, spermidine, and spermine is also elevated in some cancer patients. Their levels change in response to disease activity and therapy-induced remissions. A collaborative study is underway between Doctors Raymond R Brown and Douglass C Tormey of WCCC and Danish scientists, Doctors Hans Wolf and H R Nielsen, to measure pseudouridine, 7-methylguanine, uric acid, β-aminoisobutyric acid, and creatinine in the urine and blood and polyamines and nucleosides in the urine of patients.

Vitamin B_6, pyridoxal phosphate, is a cofactor for ornithine decarboxylase, the first enzyme involved in the synthesis of polyamines. Dietary vitamin B_6 influences polyamine production and excretion and normalizes the excretion of kynurenine, acetylkynurenine, hydroxykynurenine, and xanthurenic acid by patients with bladder cancer. These substances are carcinogenic in mice. Perhaps vitamin B_6 may retard the development of heterotopic recurrences.

It may be possible to identify persons at high risk of cancer development by studying the acetylation capability of people with bladder cancer caused by industrial arylamine exposure according to Dr Gottfried Kellermann of WCCC. Determination of genetic variations in arylhydrocarbon hydroxylase and arylamine oxidase may indicate enhanced human susceptibility. Polycyclic aromatic hydrocarbons and arylamines are ubiquitous pollutants of air, soil, and water and major carcinogenic components of cigarette smoke. Arylhydrocarbon hydroxylase activity found in most animal and human tissues is increased by exposure to various drugs and chemicals. Other carcinogen-metabolizing enzymes are epoxide hydrase, UDP-glucuronyltransferase, and N-hydroxylase. Individual ge-

[1]Fourth article in a series on studies being done on bladder cancer at the Wisconsin Clinical Cancer Center in Madison under the leadership of George T Bryan, MD.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or the State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

netic variations in one or more of these may help determine individual susceptibility to lung and/or bladder carcinogenesis. Studies have shown that lung cancer does have a genetic component. Individuals may be differentially susceptible to bladder carcinogens and have phenotypic differences in biotransformation capabilities.

New methods of treatment are being investigated. Models for evaluating potential chemotherapeutic agents have been developed using FANFT which is carcinogenic for bladder in rats, mice, hamsters, and dogs, and bracken fern which is carcinogenic for bladder in rats, mice, and cows. If antineoplastic drugs were delivered locally to the bladder, they would bathe a large part of the epithelial surface, thereby exposing surface neoplastic microfoci to greater concentrations of active drug than systemic methods. Destruction by suitable cytotoxic agents plus periodic cystoscopic removal of visible tumor may destroy adjacent or distant intraluminal neoplastic foci that are not visualized and prevent future implantation.

Nornitrogen mustard instilled into the bladder inhibited tumor growth and no microscopic foci of neoplasia developed. Other drugs were less effective in order of decreasing effectiveness: phosphoramide mustard, cyclophosphamide, thiotepa, and adriamycin. Studies are also being done with interferon and polyinosinic-polycytidylic acid. If cytotoxic agents were minimally absorbed, intravesically administered drugs might have less systemic toxicity. Liposome encapsulation systems are being developed for local therapy.

Although much remains to be done, the efforts of many physicians and scientists around the world are gradually beginning to provide an understanding of many of the complexities of bladder cancer, so that more effective strategies for preventing, diagnosing, and treating bladder cancer will be possible.

—**Dorothy J Buchanan-Davidson, PhD**
Science Writer, WCCC ■

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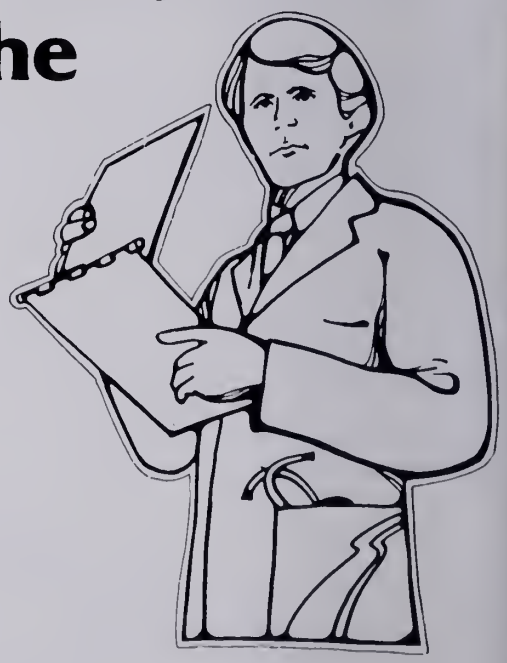

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Fin l assification of the less-than-effective indica- ion quires further investigation.
The ectiveness of Equagesic in long-term use, i e nor an four months, has not been assessed by syst tic clinical studies The physician should pe- iod y reassess usefulness of the drug for the indi- idu atient

CONTRAINDICATIONS: Equagesic should not be given to ndiv with a history of sensitivity or severe intolerance ram meprobamate, or ethoheptazine citrate
WARNINGS: Careful supervision of dose and amounts pre- bed patients is advised especially with those patients hav dpropensity for taking excessive quantities of drugs ssa and prolonged use in susceptible persons e g , hos former addicts, and other severe psychoneurot- ias n reported to result in dependence on or habit- on t e drug Where excessive dosage has continued ove r months, dosage should be reduced gradually if abruptly stopped, since withdrawal of a "crutch" pro tate withdrawal reaction of greater proportions tha which the drug was originally prescribed Abrupt mar ce of doses in excess of the recommended dose ssa in some cases in the occurrence of epileptiform ess

Ital should be taken to warn patients taking mepro- ble tolerance to alcohol may be lowered with re- ent s ng of reaction time and impairment of judgement ccu ation
USAGE PREGNANCY AND LACTATION: An in- ased of congenital malformations associated with se minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under
PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels
ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug
Impairment of accommodation and visual acuity has been reported rarely
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions
DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other su[illegible] tive measures should be used as indicated. Ga[illegible] lavage may be helpful. Activated charcoal ca[illegible] sorb a significant amount of ingested propoxyp[illegible] Dialysis is of little value in poisoning by pro[illegible] phene alone. Acetaminophen is rapidly abso[illegible] and efforts to remove the drug from the body s[illegible] not be delayed. Copious gastric lavage and or [illegible] tion of emesis may be indicated. Activated cha[illegible] is probably ineffective unless administered s[illegible] immediately after acetaminophen ingestion. N[illegible] forced diuresis nor hemodialysis appears to b[illegible] fective in removing acetaminophen. Since sev[illegible] nephrin in overdose may have an antidiuretic [illegible] and may produce renal damage, administrati[illegible] fluids should be carefully monitored to avoid [illegible] load. It has been reported that mercaptamine [illegible] teamine) or other thiol compounds may protect a[illegible] liver damage if given soon after overdosage [illegible] hours). N-acetylcysteine is under investigation [illegible] less toxic alternative to mercaptamine which [illegible] cause anorexia, nausea, vomiting, and drows[illegible] Appropriate literature should be consulted for [illegible] information. (JAMA 237 2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicit[illegible] be delayed up to one week. Acetaminophen p[illegible] levels and half-life may be useful in assessin[illegible] likelihood of hepatotoxicity. Serial hepatic e[illegible] determinations are also recommended.

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Scientific Medicine

REFER TO—Sty JR, Simons G, Rieser T: Radionuclide patterns in pediatric hip pain. *Wisconsin Med J* 79:21-23 (Aug) 1980

KEY WORDS—Bone, hip, bone imaging, phosphate complexes

Radionuclide patterns in pediatric hip pain

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Hip pain in children is a frequent problem. The etiology of the pain can usually be determined with clinical examination, radiographs, and laboratory studies. Recently nuclear bone imaging has been introduced to evaluate various benign and malignant bone afflictions in children. The characteristic scintigraphic patterns, accuracy, and technique of hip imaging in children are discussed.

THE DEVELOPMENT of ^{99m}Technetium labeled bone seeking tracers[1] and improved nuclear imaging equipment provides clinicians with excellent images at a reduced radiation burden.[2] Most skeletal lesions are demonstrated with bone imaging before radiographic change occurs[3,4,5] and may be localized to a definite anatomic site; *eg,* epiphyseal ossification center, growth plate, or metaphysis. In addition, bone imaging is a sensitive indicator of blood flow and osteogenesis[6,7,8] and may be specific when used in the proper clinical situation.[9,10]

MATERIALS AND METHODS. One hundred children, ranging in age from one month to 14 years, were evaluated. The children were referred for nuclear evaluation from the emergency, orthopedic, and pediatric departments. All children presenting with hip pain were not imaged. For example, fractures, slipped femoral capital epiphyses, or obvious osteomyelitis were not evaluated with nuclear studies or included in the study.

IMAGING TECHNIQUE. Each child received 10 mCi/1.7m^2 of ^{99m}Technetium-methylene diphosphonate intravenously. Immediate images were obtained after tracer injection with a standard collimator (early images). Delayed images were obtained 1½ to 2 hours after injection. A high-resolution collimator, as well as a pinhole collimator, were used for the delayed images. Pinhole imaging provided magnification which was necessary in small children. Sedation was not routinely required.

Table 1—Discharge diagnosis and nuclear imaging results

CASES	DISCHARGE DIAGNOSIS	RESULTS OF BONE IMAGING	
		NORMAL	ABNORMAL
49	Transient synovitis	19	30
16	Perthes' disease	0	16
4	Malignancy	2	2
20	Inflammatory disease	0	20
(5)	Septic joint	0	(5)
(10)	Osteomyelitis	0	(10)
(5)	Cellulitis	0	(5)
11	Miscellaneous		
(4)	Infarction (Sickle cell disease)	0	(4)
(1)	Exostosis	0	(1)
(1)	Osteoid osteoma	0	(1)
(3)	Trauma	(2)	(1)
(2)	Slipped epiphysis	0	(2)
100	TOTAL		

From Milwaukee Children's Hospital, Department of Radiology, Milwaukee, Wisconsin. Publication support provided. Reprint requests to John R Sty, MD, Milwaukee Children's Hospital, Dept of Radiology, 8700 West Wisconsin Ave, PO Box 1997, Milwaukee, Wis 53201 (Phone: 414/931-1010). Copyright 1980 by the State Medical Society of Wisconsin.

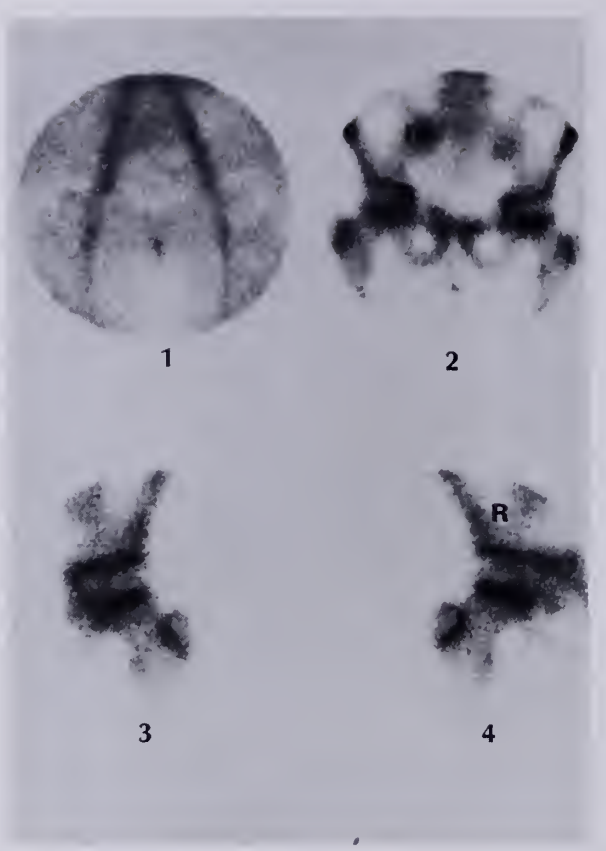

Figure 1—Normal hip images. (1) Early images. (2) Standard delayed images. (3) and (4) Magnification images using pinhole collimator.

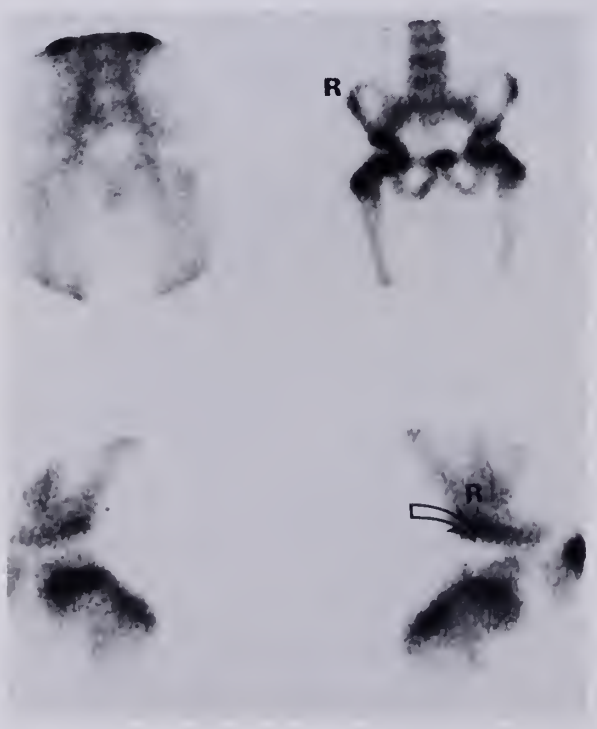

Figure 2—Legg-Perthes' disease of the right hip. Arrow marks "cold" head. The abnormality is not demonstrated with standard imaging (image directly above). There is associated synovitis causing increased activity in the right acetabulum.

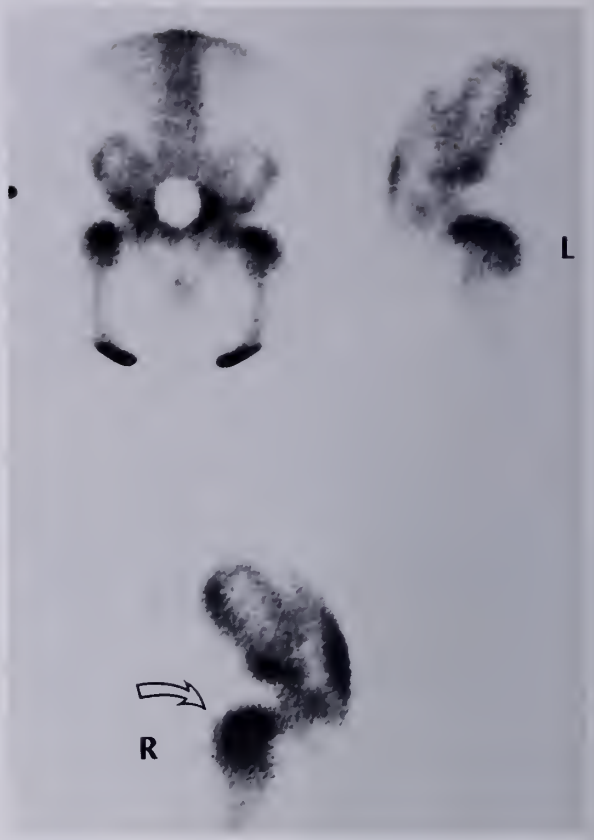

Figure 3—Osteomyelitis of the right proximal femur. Arrow marks "hot" metaphysis. The abnormality is not adequately demonstrated with standard imaging (image directly above).

Table 2—Radionuclide patterns in hip disease

	RN PATTERNS	
ABNORMALITY	EARLY IMAGES	DELAYED IMAGES
Synovitis	normal	↑activity acetabulum
Legg-Perthes'	normal	↓activity femoral head
Malignancy	variable	↑activity multifocal
Inflammatory disease		
Cellulitis	diffuse activity soft tissue	minimal↑ activity soft tissue
Osteomyelitis	focal activity bone	focal↑ activity bone
Septic arthritis	regional activity joint	regional↑ activity periarticular
Infarction	decrease normal	focal↓ activity

RESULTS. All the radionuclide examinations were technically satisfactory. The uninvolved hip served as a control for comparison for pinhole imaging.

Table 1 lists the discharge diagnosis and nuclear imaging results. The discharge diagnosis was based on radionuclide bone images, radiographs, blood studies, clinical course, and biopsy if indicated. Each child was followed clinically for greater than nine months.

Figure 1 illustrates normal hip images. Figure 2 illustrates a four-year-old with Legg Perthes' disease. Figure 3 illustrates a three-month-old with osteomyelitis. Table 2 lists the radionuclide pattern in the more common hip disorders in children.

DISCUSSION. The clinical differentiation of hip pain in children is difficult but frequently made on the basis of history, careful physical examination, and standard laboratory studies. However, while the "typical physical findings" are diagnostic, they may not be present, leading the clinician to rely on radiographic findings which may be absent in the early stages of diseases.[11,12,13,14] Occasionally different clinical diseases may have similar physical findings. For example, children with toxic synovitis, septic arthritis, osteomyelitis with sympathetic effusion, or bone infarction associated with sickle cell disease may all have limited range of motion, fever, and failure to bear weight on the affected limb. Also toxic synovitis may be difficult to separate from Legg-Perthes' disease if the radiographs are normal.

The radionuclide technique described proved to be a valuable diagnostic tool when the clinical diagnosis was uncertain. Others also have found this method reliable.[14,15]

The mechanisms of skeletal uptake of bone seeking tracers have recently been reviewed.[16] Blood flow to bone is necessary for tracer uptake in the skeletal system, and quantity of uptake is related to osteogenesis (normal bone formation, reactive bone formation, malignant new bone, or destruction without reaction). When patients are imaged immediately following injection of bone seeking tracer, lesions which are hypervascular are readily defined as regions of increased tracer accumulation. For example, cellulitis demonstrates increase tracer accumulation in the soft tissues, as opposed to osteomyelitis where tracer accumulation is in the bone. The delayed bone images which are obtained two hours after injection of tracer represent the combined mechanisms of blood flow and osteogenesis.

Bone imaging is a sensitive diagnostic method that can be used to detect orthopedic hip abnormalities early in evolution. The radionuclide technique examines the pathophysiology rather than the structural abnormalities which are defined with standard radiography. The structural abnormality usually lags well behind the early pathophysiologic abnormality.

We found radionuclide hip imaging useful in (1) differentiating between inflammatory processes [septic arthritis, cellulitis, or osteomyelitis]; (2) documenting early Legg Perthes' disease; (3) differentiating transient synovitis from synovitis associated with Legg Perthes' disease; (4) documenting metastatic disease; and (5) defining areas of minimal osseous trauma with normal radiographs.

The largest number of children studied in our series had the discharge diagnosis of toxic synovitis. Nineteen of the 49 children had normal radiographs and bone scans. These children had mild disease which quickly responded to either nonweight bearing or traction. The remainder of the children demonstrated slightly more symptomatology but responded equally well to therapy. No child in this group eventually developed Legg Perthes' disease. We feel this is useful clinical information.

Although bone imaging is more sensitive than the radiographs in detecting skeletal metastases,[3] the examination may not detect abnormality if leukemia is responsible for bone pain. We studied two children with hip pain who had normal scans; later these children developed leukemia. Frequently marrow examination is necessary to evaluate bone pain in the absence of positive scintigrams or radiographs in children.

SUMMARY. Numerous conditions which are atypical or early in the stage of evolution may appear to the clinician as enigmatic on the basis of the history, clinical examination, and routine radiographs. The enigma may frequently be quickly resolved through the use of bone imaging.

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REFER TO—Folts JD: Platelet aggregation in stenosed coronary or cerebral arteries: A mechanism for sudden death? *Wisconsin Med J* 79:24-27 (Aug) 1980

KEY WORDS—Platelet aggregation, epinephrine, aspirin, cigarette smoke, sudden death

Platelet aggregation in stenosed coronary or cerebral arteries: A mechanism for sudden death?

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Platelet aggregates appear to form in canine coronary and cerebral arteries mechanically narrowed from 60-80%, temporarily obstructing the blood flow. These aggregates produce transient ischemia and in some cases death of the animal by ventricular fibrillation. This transient ischemia caused by platelet plugs can be prevented with the known platelet inhibitor acetylsalicylic acid 35 mg/kg intravenously. This plugging phenomenon can be exacerbated with 50 μg of epinephrine intravenously or by ventilating the dog with five puffs of cigarette smoke which often leads to fatal arrhythmias. Aspirin does not protect against platelet plugging caused by cigarette smoke. Using a noninvasive Doppler flowmeter, we have observed what may be platelet plugging in the popliteal arteries of six men, and these disappeared after 600 mg of aspirin.

THE MAJOR CAUSE of sudden death in the United States today is coronary heart disease.[1] While it is accepted that atherosclerotic narrowing of coronary arteries is the main pathologic abnormality, the fact remains that postmortem examination of those dying suddenly usually fails to show recent sudden total occlusion of vessels or recent myocardial infarction so the mechanism responsible for sudden coronary death remains in doubt. In the course of studying the physiological consequences of coronary artery narrowing in a canine model, we noted a cyclic phenomenon in which there was a decline in coronary flow over a 5-10 minute period, often to zero flow. This was accompanied by a decrease in peripheral coronary arterial pressure and with the appearance of ischemic ECG changes, followed either by an abrupt return to control flow values and disappearance of ischemia or by sudden onset of ventricular arrhythmia, fibrillation and death.[3,4]

Accordingly, a series of experiments was conducted in 52 open chest anesthetized dogs, where coronary blood flow was continuously measured using electromagnetic flow probes. Coronary stenosis was produced using a plastic cylinder which encircled the external surface of the coronary artery so as to produce 60-70% narrowing of the vessel as previously described.[3,4] The degree of stenosis was confirmed at the end of the experiment by injecting the narrowed coronary artery with Silastic rubber under physiologic pressure and making a cast of the coronary artery.[5] Sections of the normal coronary artery and the stenosed portion of the artery were examined microscopically, and the percentage of stenosis determined. This amount of stenosis just eliminates the reactive hyperemic response to a 20-second temporary complete occlusion.[4,5] Observation for one hour revealed that in 85% of animals with a 60-80% coronary artery stenosis, periodic reductions in flow occurred followed by an abrupt return to control values. These cyclical flow reductions are never seen in vessels with less than 40% stenosis. An example of these cyclical reductions in coronary flow is shown in Figure 1. In 16 of these dogs, 60-80% stenoses also were produced in the carotid artery using the plastic cylinders. In 10 of the 16 dogs, cyclical blood flow reductions were observed in the carotid artery, as measured with an electromagnetic flowprobe.

It was postulated that these flow reductions were caused either by fibrin clots or platelet aggregates forming in the narrowed lumen and then breaking loose and being carried down stream. The administration of 8000μ of intravenous heparin, which is known to inhibit fibrin deposition but not platelet aggregation, did not abolish the flow reductions. However, the intravenous administration of 35 mg/kg of acetylsalicylic acid abolished the spontaneous flow reductions in all cases.[3,4]

We previously have done studies of in vitro platelet aggregation on a Sienco platelet aggregometer using the technique of Born[6] with ADP (adenosine 5′-diphosphate) as the stimulus. These studies were carried out to establish whether a difference in platelet behavior could account for the

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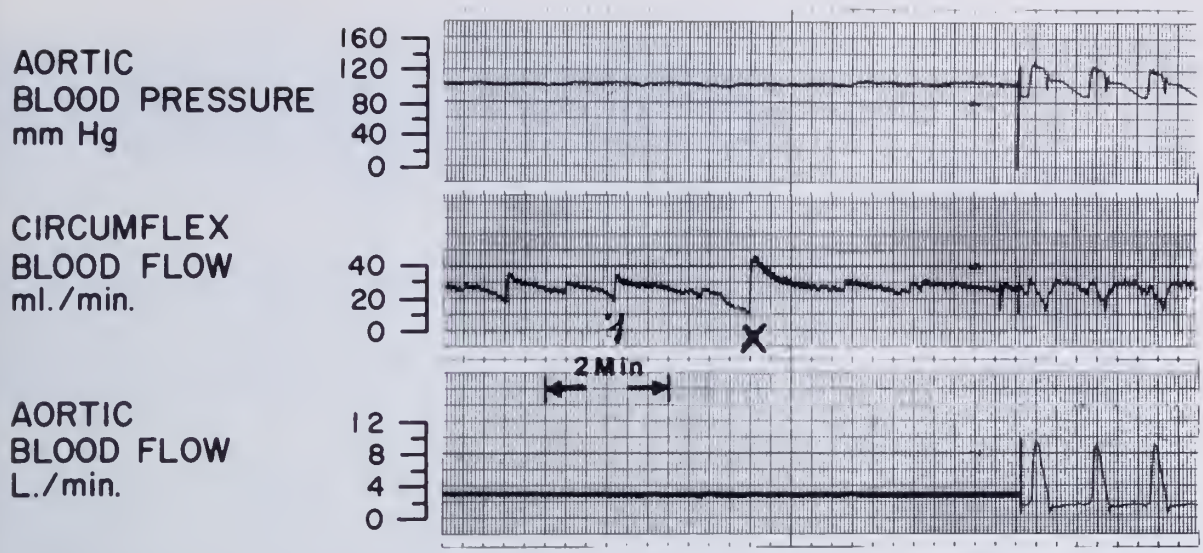

Figure 1—Mean aortic blood pressure, circumflex coronary blood flow and aortic blood flow as a measure of cardiac output. The mean coronary flow in the artery which has a 70% stenosis periodically declines to low levels with spontaneous recovery to near normal levels, while aortic blood pressure and flow remain constant. This change in coronary vascular resistance is due to platelet aggregates forming in the narrowed lumen.

fact that the observed periodic changes in flow occurred in only 85% of the animals. Platelet aggregation was recorded on a scale varying from 10-90 arbitrary light transmission units where the higher numbers indicate a greater platelet aggregation. These studies established that in those dogs which showed the periodic flow reduction, there was a much higher in vitro platelet aggregation (62 ± 15 units) than the animals which failed to exhibit the phenomena (34 ± 16 units) ($P < .005$). The reason for impaired platelet aggregation in 15% of the dogs is as yet unclear.[4]

In 20 animals when the coronary flow had decreased to low levels, the vessel was quickly ligated distally and then proximally and excised. Histologic sections made of the narrowed lumen showed that it was filled with platelet aggregates.[4] In ten dogs which failed to show cyclical reductions in flow, the stenosed vessel also was removed and platelet aggregates were never seen in the stenosed lumen, nor have they been seen in vessels examined which had only the flow probe placed on the vessel but without stenosis. In another study in which blood flow was measured simultaneously in a stenosed circumflex coronary artery and a normal unstenosed left anterior descending coronary artery, cyclical flow reductions were observed in the stenosed artery but never in the normal artery.[7]

Preliminary studies were done to determine if vasospasm plays a role in these cyclical flow reductions. In 15 dogs vasodilating agents such as dipyridamole (Persantine®) 1 mg/kg, papaverine 1 mg/kg, and nitroglycerin 0.5 mg/kg were sprayed topically on the narrowed coronary artery; and these agents also were injected intravenously. None of these agents significantly altered the cyclical flow reductions. However, known platelet inhibitors, such as aspirin 35 mg/kg, abolished the cyclical flow reductions.[4,8,9,10] Agents such as oleic acid 7.5 mg/kg or epinephrine 2 μg/kg injected intraveneously exacerbated this platelet plugging and increased the size of the cyclical flow reductions.[8,10] A representative example of the exacerbation of the size of cyclical flow reductions by epinephrine is shown in Figure 2. In an abstract we have shown that ventilating the dog with five puffs of cigarette smoke greatly exacerbates the platelet plugging in these 60-80% stenosed coronary arteries and that this could still occur after 20 mg/kg of aspirin intravenously.[11] We are presently attempting to determine how cigarette smoke apparently overcomes the intended beneficial effect of aspirin in preventing platelet aggregation in stenosed coronary arteries. It has been shown previously that smoking cigarettes increases platelet aggregation measured in vitro.[12]

In man, atherosclerotic narrowing of coronary or cerebral arteries could provide a stenosed surface which would be likely to promote platelet aggregation. Furthermore, cigarette smoke,[11,13] type II hyperlipoproteinemia,[14,15] diabetes, [16,17] and type A personality, (where epinephrine levels are increased)[18] are known to be associated with an increased platelet aggregation tendency in man and this may well be why these factors have been shown to increase the risk of sudden death in patients with diseased coronary arteries. A platelet aggregate, obstructing a narrowed coronary artery, even temporarily, could result in ischemia, which then leads to arrhythmias and sudden death

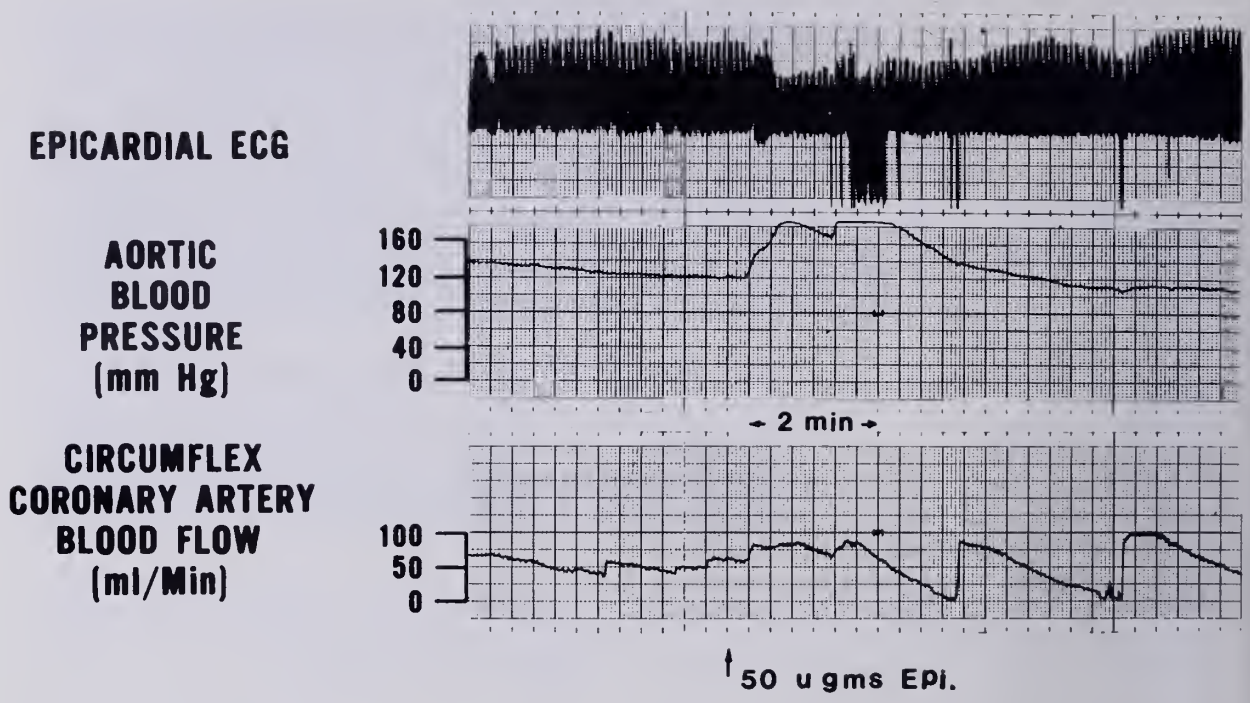

Figure 2—Mean arterial blood pressure and circumflex coronary blood flow in a coronary artery given a 76% fixed mechanical stenosis. In the center, 50 μg of epinephrine was injected intravenously. The rate of decline of coronary blood flow is greatly increased, and at point x it was necessary to poke the vessel, to physically dislodge the platelet plug, to restore flow and prevent the death of the animal.

just as it does in the canine model. We have observed cyclical flow velocity reductions in the popliteal artery in six of ten patients, not taking aspirin, with angiographically proven peripheral vascular disease, measured with a noninvasive Doppler ultrasound flowmeter.[19] The six patients in which cyclical flow velocity reductions were noted were given aspirin (600 mg) and restudied one hour later and in five of six patients there were no longer any cyclical flow velocity reductions noted in the popliteal artery during the 45-minute observation period.[19]

Preliminary data indicate that prolonged aspirin treatment in man may reduce the incidence of sudden death[20] and reduce transient ischemic attacks.[21] We also have shown that in chronically instrumented dogs in which the plastic cylinder and flowmeters are surgically implanted under sterile conditions, the animals will show cyclical flow reductions postoperatively. They can be abolished for two to three days at which time they gradually return (unpublished observation). We feel this must be a direct effect on the platelets where the acetyl group of ASA complexes with cyclooxygenase and permanently inhibits platelet aggregation. If vasospasm were involved, one would not expect a two to three day effect from some agent that exists in the plasma for only two hours.

A variety of platelet inhibitors, in addition to aspirin, are being tested currently in our animal model, our patients, and large numbers of patients throughout the country. The present studies furnish a promising lead for further investigation into the important question of sudden coronary death and stroke.

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continued►

Abstracts

Presented at the Spring Meeting of the Wisconsin Neurological Society
May 9-10, 1980, Madison, Wisconsin

Francis M Forster, MD, Madison, Program Chairman

Brainstem sequelae of Reye's syndrome

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Milwaukee, Wisconsin

Two children who survived Reye's syndrome had neurological sequelae manifested by brainstem findings. The first, a 14-year-old girl, entered in stage II, was treated with intravenous mannitol, and deteriorated to stage III within 36 hours. Pentobarbital coma was initiated and maintained for four days. She responded to pain 48 hours after the pentobarbital was discontinued. During her three months of hospitalization, her mentation improved; other findings were a mild right hemiparesis, vertical and horizontal nystagmus, difficulty swallowing with documentaion on barium swallow, weak gag, and bilaterally abducted vocal cords. At discharge her IQ, using the WISC-R and the Peabody Individual Achievement Test, showed average intellect and scores at her grade level.

The second child, a 14-year-old boy, entered in stage II, was treated with glycerol, mannitol, and peritoneal dialysis for an ammonia over 1000. He progressed to stage IV and was comatose for two weeks. During his three months of hospitalization, he exhibited vertical and horizontal nystagmus, weak gag and swallowing dysfunction, difficulty with tongue control, and dysarthria. He is now attending a regular school with IQ in the dull-normal range.

Neurological sequelae of Reye's syndrome have generally been reported as supratentorial; *ie,* spasticity and mental retardation. Previous work has suggested a relationship between brain damage and decreased diastolic blood pressure, presuming decreased perfusion. In our first patient diastolic blood pressure was less than 50 mm Hg twice for one hour's duration; in the second, it was less than 50 mm of mercury for four hours. It is unclear how much of their prolonged coma was brainstem versus a cerebral process. Their sequelae may be secondary to decreased perfusion, direct pressure effects (*ie,* herniation) or possibly from Duret hemorrhages. Brainstem abnormalities have not been reported as a part of Reye's syndrome sequelae. ■

Hypersomnia associated with alveolar hypoventilation in myotonic dystrophy

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A 38-year-old gentleman who was thought to have narcolepsy for 18 years was evaluated at the Marshfield Clinic Sleep Laboratory. Treatment for narcolepsy had been successful. Evaluation, including electromyelographic studies and muscle biopsy revealed myotonic dystrophy. Pulmonary function tests showed alveolar hypoventilation.

Polysomnographic studies revealed some mixed type apneic episodes in sleep, but not enough to account for his hypersomnia. Sleep cycles were normal and neither REM excess nor REM onset of sleep were observed. Daytime sleep showed no REM. The brainstem auditory evoked response was normal. Routine laboratory and endocrine studies and the MMPI were normal.

Alveolar hypoventilation and hypersomnia both seem to have central origins in myotonic dystrophies. No association with narcolepsy or sleep apnea syndrome has been observed. A review of the literature on hypersomnia and alveolar hypoventilation in myotonic dystrophy seems to confirm our conclusions. ■

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KEY WORDS—Esophageal reconstruction, epidermolysis bullosa, congenital disease, squamous epithelium

Staged esophageal reconstruction in epidermolysis bullosa

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Epidermolysis bullosa is a congenital disease in which the squamous epithelium readily separates from the underlying layers. Management of related esophageal strictures has been limited in the past because of the potential risk of exacerbating the underlying disease process through operation or instrumentation. Gratifying results in these patients are possible with an aggressive approach employing esophageal replacement by colon interposition.

EPIDERMOLYSIS bullosa is a debilitating congenital disease of the squamous epithelium, characterized by deficient binding of the basal cells to the underlying layers.[1] As the result of even minor trauma, separation of the epithelium readily occurs, forming bullae which later ulcerate, become infected, and heal by scarring. With repeated insults severe contractures occur. Losses of skin appendages, digits, and teeth are common.

Although esophageal involvement is less frequent than such external manifestations, occurrence of esophageal stricture is no less debilitating. Management of this problem is particularly challenging. The present report describes a long-term survivor with epidermolysis, in whom postemetic esophageal perforation was successfully managed by emergent esophagectomy and delayed reconstruction.

CASE REPORT. A 34-year-old woman presented to the emergency room because of the sudden onset of chest and abdominal pain. She had suffered from recessive epidermolysis bullosa since birth, manifested by continuing recurrent episodes of cutaneous bullae, ulceration, and scar contractures. Involvement had become particularly severe over pressure points and skin folds, with loss and fusion of the fingers secondary to trauma and infection (Fig 1). Although a sibling died in early life of the same condition, the patient had survived into adulthood, performing a large part of her own care, holding a regular job, and remaining physically active.

Dysphagia was first noted 15 years previously. A barium swallow showed an esophageal stricture at the upper third (Fig 2); but because of the danger of inducing further injury and scarring, no therapy was recommended. The patient's symptoms progressed, and eventually she could subsist only on a blenderized regimen. During a meal several hours prior to admission, she experienced a severe episode of dysphagia followed by retching and then sharp anterior chest and epigastric pain radiating to the back.

Figure 1—Severe deformity of left upper extremity, with loss and fusion of digits.

Examination revealed an acutely and chronically ill female with a low-grade fever, mild respiratory distress, and severe cutaneous manifestations of epidermolysis bullosa. Crepitus was noted in the neck, and the abdomen was quite distended, tympanitic, and tender. An upright chest x-ray film revealed cervical and mediastinal emphysema and free air beneath both diaphragms (Fig 3). Diatrizoate meglumine and diatrizoate sodium solution (Gastrografin®) swallow showed deviation and widdening of the contrast column beginning at the level of the aortic arch with rapid flow into the peritoneal cavity (Fig 4), consistent with esophageal perforation at the origin of the previously demonstrated stricture.

Because of total lack of peripheral venous access, a supraclavicular central venous catheter was inserted and maintained for all fluids and medications during the operative and postoperative periods. After a brief period of rehydration and administra-

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Figure 2—Barium swallow, revealing stricture beginning at upper third of esophagus.

Figure 3—Emergency room radiograph with pathognomonic findings of esophageal perforation.

tion of broad-spectrum antibiotics, a right-sided thoracotomy was performed under general anesthesia. The mediastinum was acutely inflamed, with egress of cloudy fluid upon opening its pleural reflection. The esophagus was extensively destroyed, perforation having occurred at the upper third as predicted and dissection having extended intramurally down into the abdomen. Because closure or repair was not feasible, the mediastinal pleura was opened widely; and total thoracic esophagectomy was performed. To avoid aspiration of saliva and secretions, a proximal cervical esophagostomy was placed at the left side of the neck; and after irrigation of the peritoneal cavity, pyloromyotomy and gastrostomy were performed via a midline laparotomy. All of these incisions were placed so as to avoid the multiple cutaneous lesions insofar as possible. The patient was maintained on antibiotics and intravenous hyperalimentation, with a satisfyingly smooth postoperative course. By the time of discharge ten days later, gastrostomy tube feedings had begun and all wounds had healed without problem.

Figure 4—Deviation and extravasation of contrast material on lateral view, consistent with perforation at the upper third of the esophagus.

Figure 5—Severe skin breakdown secondary to both epidermoloysis and to continued salivary drainage from cervical esphagostomy.

She was followed closely in the outpatient clinic with plans for esophageal reconstruction after several months. However, due to continued abdominal cramps and diarrhea secondary to the high caloric tube feedings, and because of both increasing skin maceration around the constantly wet cervical esophagostomy (Fig 5) and inability to wear an appliance, she was readmitted for definitive operation.

Six weeks following the first procedure, and after the appropriate preparations, esophagocologastroplasty was performed, with substernal interposition between cervical esophagus and stomach, of an isoperistaltic segment of right and transverse colon, based on the left colic artery. No respiratory problems occurred in spite of endotracheal intubation during this or the previous procedure. Once again, the patient was treated with antibiotics and intravenous hyperalimentation, with good wound healing and patent and secure anastomoses by barium swallow (Fig 6). At the time of discharge two weeks later, she was on a regular regimen without problem and gaining weight. She continues to do well and remains active. She no longer requires a liquid regimen.

DISCUSSION. Successful management of esophageal perforation requires an aggressive diagnostic and therapeutic approach. Although the present case was apparent from the history and extensive dissection of air seen on chest x-ray film, contrast swallow was still necessary to define the level of perforation and plan the appropriate operation. It is our opinion that preoperative endoscopy is rarely indicated in such a situation, as it is a low-yield procedure compared to contrast x-ray studies, and further adds to delay in definitive management.

Regardless of etiology, many patients with thoracic esophageal perforations and mediastinitis are practically moribund when first seen, and an attractive concept would be management in the least traumatic and extensive fashion. In reality however, this is usually not possible nor advisable; and no less than aggressive surgical treatment will be lifesaving. Our patient required wide incision of the mediastinum; and since repair or closure of the esophagus was not feasible, esophagectomy was performed, with survival of the patient. A lesser procedure, such as simple drainage or antibiotics only, would not have eliminated the source of continuing contamination and would likely have resulted in her demise.

As with squamous epithelium elsewhere, in which trauma results in bullae, ulceration, and eventual scarring, esophageal stricture in epidermolysis

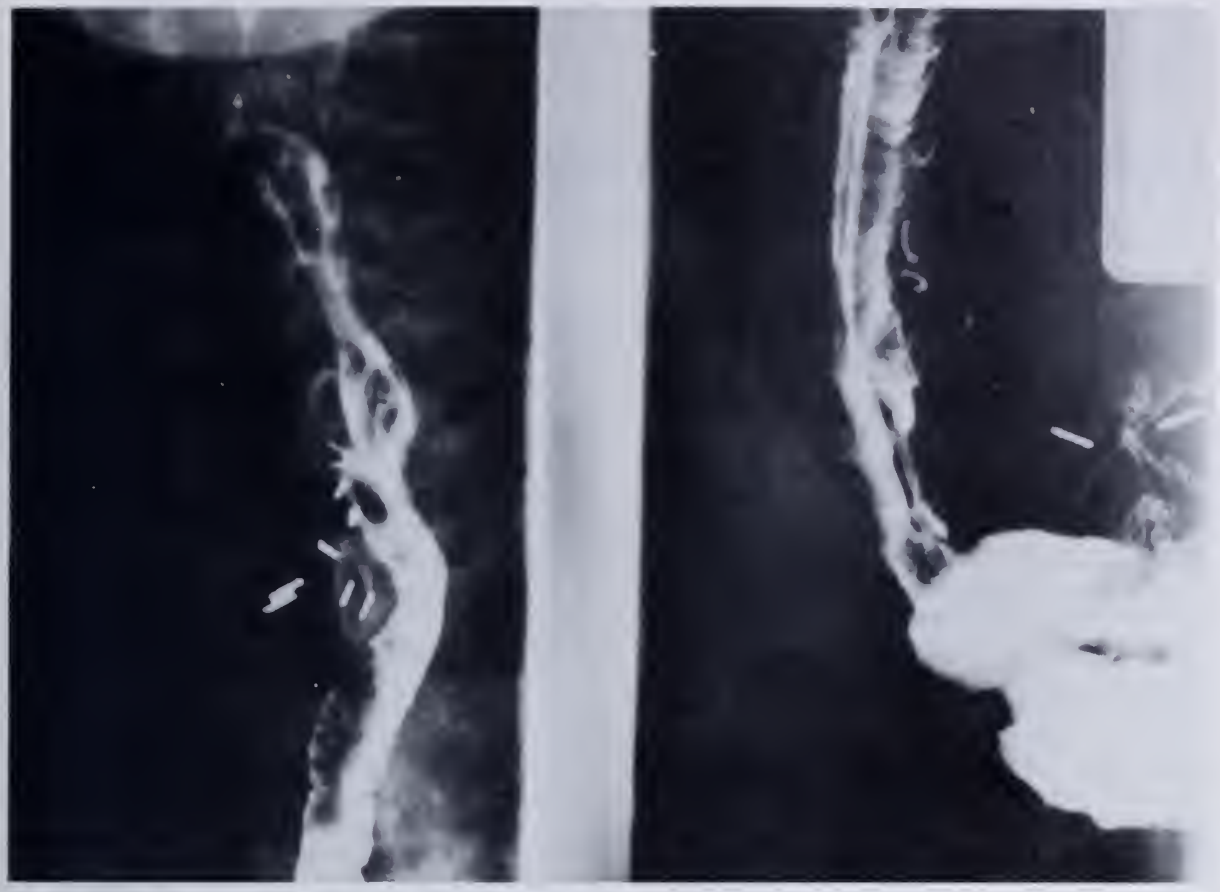

Figure 6—Postoperative study following colon interposition. The proximal esophagocolonic (left) and distal colo-gastric (right) anastomoses have healed well.

bullosa occurs from repeated irritation secondary to ingestion of foods. With chronic inflammation and progressive stricture, pain and dysphagia develop, and solid meals are eventually no longer tolerated[2,3] Most such patients in the past have been managed by liquid regimens or tube feedings, as steroids have not been beneficial[4] and mechanical dilatations carry the risk of further trauma and scarring, with perforation or extension of the stricture.[5]

Since the oropharyngeal mucosa is remarkably spared and because the entire esophageal mucosa is subject to repeated trauma, the ideal treatment for such a situation would seem to be total replacement from pharynx to stomach, using a non-squamous lined tube such as colon. This was first undertaken in two patients by Absolon, et al in 1969,[5] with excellent results at 5-year followup;[6] and since then, two other cases have been reported,[7,8] also with gratifying results. To our knowledge the present case is the fifth reported successful esophageal replacement in epidermolysis bullosa, and the only one in which the initial esophagectomy was performed as an initial, emergency procedure, rather than on a single stage, planned basis.

Although the underlying etiology of epidermolysis bullosa is still unknown and individual surgical experience for related esophageal strictures is limited, such patients no longer require chronic management by tube feedings or liquid regimens, as reconstruction by colon interposition offers a promising alternative. With demonstrated good wound and anastomotic healing in these patients, an aggressive surgical approach is warranted.

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KEY WORDS—Hypertension, adolescent screening, preventive medicine

Hypertension screening of adolescents in Central Wisconsin—A Ward Ford Memorial Institute

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BLOOD PRESSURE screening in various adult populations is now an accepted tool of preventive medicine. On the other hand, screening procedures involving children and adolescents have not been widely accepted for a number of reasons. Authoritative groups, including the Task Force on Blood Pressure Control in Children, have recommended that screening programs for hypertension in children should be discouraged although they do favor annual blood pressure checks for children two years of age or older. They advocated plotting the blood pressure measurements on grids and reserving complete evaluation for those subjects whose levels exceeded the ninety percentile. In blood pressure determinations they preferred the fourth phase Korotkoff sound for determining diastolic pressures.[1,2]

Only recently has it been acknowledged that primary hypertension may occur in children, and in fact, earlier studies indicated that a specific cause for hypertension could be found in from 75 to 90 percent of children when a complete diagnostic evaluation was conducted.[3,4,5,6,7] Loggie, who at one time advocated the rarity of essential hypertension in children and adolescents, recently commented, "We are wiser now having learned that (essential) hypertension is not uncommon in children and adolescents and that observations made largely at referral centers serving severely hypertensive children may have represented a misleading picture in terms of etiology."[8]

In conjunction with our established hypertensive screening program in North Central Wisconsin, we decided to enter the field of adolescent screening with particular regard to obtaining information regarding a familial pattern and the question of certain environmental influences such as cigarette smoking and high blood pressure medication itself in addition to the actual incidence of elevations in this age group.

METHOD. The three largest high schools in the area were selected for the initial screening effort. The population of this region is almost one hundred percent Caucasian and includes industrial families as well as those primarily in agricultural pursuits. German and Polish backgrounds predominate. The lack of significant black population should not be underestimated since after puberty blacks apparently have higher levels of pressure than Caucasians matched for age and sex.[2] In the absence of established "cut-off" points for blood pressure screening of adolescents we used the adult level cut-off points of 140/90. As in the adult screening, we used a fifth Korotkoff sound for determination of diastolic pressure since no children under high school age were included.[1]

In order to get additional information, a questionnaire* (Part I) was completed by each student prior to the blood pressure determination. In addition, the parents also were sent questionnaires* (Part II), but despite the emphasis on the importance attached to this part of the study, only one third of the parents at each school responded to our requests.

RESULTS. The total number of students screened in the three large and three small high schools in the area was 3,478. Of this entire number, 291 (8.4 percent) were positive at the time of the initial examination and asked to return for recheck. However, only 132 (45 percent) returned for a recheck and of those 60 (46 percent of the rechecks) were positive at the end of rechecking. If we assume that the 46 percent figure is representative of the entire group, we would postulate that if all of the 291 patients had returned for rechecks, 132 would have been positive. This would have repre-

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*Questionnaires are available from the authors.

sented 3.8 percent of the entire group originally screened.

GROUPING OF STUDENTS WITH PARENTAL FORMS. A total of 1,351 parental forms were returned (38 percent). We consider this a disappointing figure, although school officials consider that it was a rather satisfactory return. Of all students with parental forms returned (1,351), 152 or 11.5 percent showed initial elevation in contrast to 6.5 percent for students where no forms were returned (Table 1). Of the total number of parental forms returned, there were 455 (34 percent) in which one parent was positive in his answers to either question one or two on the parent questionnaire. Of these 455, we matched 69 positive children (15 percent) and 386 negative children (85 percent).

Of the forms returned in which both parents indicated a positive answer to either question one or question two, there were 74. Matched with this group were 23 positive children (31 percent) and 51 negative children (69 percent).

The parents with negative answers to questions one and two on the parent questionnaires totaled 819. These were matched with 94 positive students (11.5 percent) and 728 negative students (88 percent).

Only three students in the entire group (0.1 percent) admitted to being on blood pressure medication at the time of the check.

Of the students who showed an elevated reading at the first examination, 21 percent gave a history of smoking. Of those with normal blood pressures there were only 2 percent who smoked (Table 2).

Of the students who had an initial positive blood pressure reading, regardless of whether a parental form was returned, 19 percent had a family history of "heart trouble" while this was true in only 1 percent of the normal blood pressure readings. The same percentage differences were maintained for the most part with stroke and diabetes, each of which showed more than a tenfold increase in incidence in those showing an initial positive blood pressure reading over those with a negative reading. The increase in family history of kidney disease was less marked.

Of the total number of students positive after recheck examination, 25 percent were obese to some extent and 9 percent showed greater than 20 percent obesity. In students with no blood pressure elevation, 15 percent showed moderate and an additional 1 percent marked obesity (Table 3).

DISCUSSION. We attempted to screen the blood pressure of all the high school students in this mid-Wisconsin area. Disappointing to us was the rather low number of returns of parental forms and the rather poor showing of the students for recheck examinations after having been positive at the time of the original blood pressure test.

Wilbur has stated that rechecks in the adult population produce no great changes in the final figures, but this certainly does not hold for adolescents.[9] Johnson, et al, in checking casual pressures found an initial elevation percentage as high as 19 percent in males with 12.7 percent in females, while Kilcoyne found a 5.4 percent incidence of systolic elevation at the time of the initial screening and 7.8 percent in diastolic hypertension, but this declined to 1.2 systolic and 2.4 diastolic with rechecks.[3,10] Londe found

Table 1—Incidence of variables in students with parental forms as related to initial blood pressure

Positive family history from forms of	*Total 152 Elevations*		*Total 1174 No Elevations*	
	Number	*Percent*	*Number*	*Percent*
Heart Disease	29	19	13	1.0
Kidney Disease	3	2	7	0.6
Stroke	12	8	6	0.5
Diabetes	23	15	8	0.7

Table 2—Incidence of smoking

	Smoking		*Non-smoking*	
	No.	%	No.	%
All students with elevations	60	21	231	79
All students with parental forms and initial elevation	21	14	131	86
All students with normal blood pressure on initial examination	59	2	3128	98
All students with parental forms and normal blood pressure on initial examination	11	1	1169	99

Table 3—Incidence of obesity in students with blood pressure elevations

	Overweight 0 to 20%	Overweight Over 20%	Total
No elevation	15%	1%	16%
Elevation	25%	9%	34%

Table 4—Relation of parental history to student's initial blood pressure elevation

NO PARENT FORMS—6.5 percent with elevation

WITH PARENT FORMS—11.5 percent with elevation

A) Parents negative—11%
B) One parent positive—15%
C) Two parents positive—31%

CHILDREN SHOWING INITIAL ELEVATION—

With positive parent forms—41%
With negative parent forms—2%

a 2.3 percent incidence of elevation for ages 4 through 15 while Logge and Masland cite a figure of 1.4 percent.[4,11,12] Rames reported 13 percent with initial elevations but only 1 percent persistent.[13] The majority of these investigators made repeated rechecks. Our figure of 3.8 percent positive following a single recheck would undoubtedly be considerably reduced after further additional rechecks.

It is interesting to speculate on the significance of those students with initial elevations whose later readings are normal and those students who fall consistently in the "high-normal" range (130/80 to 130/90). Approximately 20 percent of our entire student population fell in this group. It has been postulated that even labile hypertension in the child may be a prelude to essential hypertension in later life.[11,14,15,16,26] The risk for development of sustained hypertension in this group is said to be about twice normal.[17] Reynolds believes that the labile hypertensive represents the first stage in the development of essential hypertension.[18] Londe has stated that labile hypertension in the child with a positive family history and/or history of obesity is likely to be a primary. He thinks that casual blood pressure readings may be very important.[19]

The question of what constitutes normal blood pressure for the child and young adult is still controversial. Blood pressure increases with age, and most investigators agree that for the age group that we are investigating, the 95th percentile for systolic blood pressure will be about 138 mmHg while diastolic will be about 95 mmHg[7,19,20] Rance believes that upper limits for the 13 to 14 age group should be 128/92.[21] Lieberman states that pressures above 120/80 in this age group probably represent a hypertensive value.[2]

We found no significant sex difference which Kilcoyne thinks is most marked in the younger age groups. However, she also found that this sex difference became insignificant when repeated retesting was taken into consideration.

Almost all investigators have agreed that weight is extremely important and constitutes a risk factor under age 30 and that maintenance of ideal weight in this age group may actually be a preventive measure.[10,22] Rames found 23 out of 41 of the hypertensive children to be obese.[13] In Stamler's series the prevalence of hypertension was three to four times as high in the obese group.[20] Londe found obesity in 53 percent of his adolescent hypertensives.[23] Dawber has raised the question of whether blood pressure elevation in the obese individual is real or an artifact. This question probably can be settled definitely only with invasive monitoring.[24] Furthermore, the cause and effect relationship between obesity and hypertension has not been settled.[25] In our series we found that about twice as many students with initial blood pressure elevation were overweight as compared to the group with no blood pressure elevation (Table 3). The greatest discrepancy came in those students who were overweight by 20 percent or more.

Another very important factor was that of the positive family history for hypertension which has been mentioned by all investigators. In Stamler's series the positive family history was associated with the prevalence of hypertension double that in people with negative history.[20] Reynolds considered it the best predictor for future hypertensive difficulty in the adolescent.[8] Londe found positive family history in 44 percent of his series.[26] In our group 41 percent of children with positive parent forms showed initial elevation as against only 2 percent with negative parent forms (Table 4).

A most interesting finding came out of our study. In Table 4 it will be noted that students in whom no parent forms were returned had an incidence of initial elevation of only 6.5 percent while that group of students in whom the parent forms were returned showed an 11.5 percent incidence of elevations. We believe that this is probably best explained by the fact that those parents who were aware of hypertensive difficulty in themselves or in their family would be more conscientious in returning the forms which would aid in the search for signs of hypertension in their offspring.

Of equal interest was the marked increase in incidence in family history of heart, kidney disease, and diabetes in those students who showed an initial elevation of blood pressure (Table 3). The smoking incidence followed the same pattern, averaging 21 percent in those with an initial elevation and only 2 percent in the normal group (Table 2).

SUMMARY. A total of 3,478 white high school students in Central Wisconsin were screened for hypertension. Eight and four tenths percent were positive initially, but only 3.8 percent remained positive after rechecks. Parents completing their questionnaires had twice the number of children with elevations as against those who did not. Where both parents had positive questionnaires, the incidence of elevation in offspring was three times that of those with negative forms. Students with initial elevations were ten times more likely to smoke or have a family history of heart trouble, diabetes, or stroke. Obesity was more prevalent in students showing elevations, being most marked in students with greater than 20 percent obesity.

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KEY WORDS—Mercury toxicity, poisoning, dental amalgam, paresthesia

Mercury poisoning in dentistry

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A dental assistant presented with paresthesia, fatigue, and dropping dental instruments. Urinary mercury levels were in the toxic range. After a malfunctioning amalgamator was replaced, the patient's symptoms resolved. Because of the nonspecific symptom complex, elemental mercury poisoning may be more prevalent than previously reported. Furthermore, chronic exposure to high mercury vapor levels in the dental office may pose a threat to fetuses of pregnant dental personnel.

WHILE ORGANIC mercury has been associated with the majority of mercury toxicity seen clinically, elemental mercury poisoning can produce numerous symptoms including dementia, depression, deafness, tremor, paresthesia, abdominal pain, and other somatic complaints. At the present time dentists use large quantities of inorganic mercury in the preparation of dental amalgam. While few cases of mercury poisoning have been reported in dental personnel, studies show that up to one-half of dentists have elevated blood mercury levels.[1] The following case of mercury poisoning in a dental assistant exemplifies the problem of mercury poisoning in dentistry.

Work was done when Doctor Hooper was an internal medicine resident at the Gundersen Clinic Ltd, LaCrosse, Wisconsin and supported by grants from the Gundersen Medical Foundation. Reprint requests to Doctor Hooper's current address: Philip L Hooper, MD, Ambulatory Care Clinic, Veterans Administration Medical Center, 2100 Ridgecrest Drive SE, Albuquerque, New Mexico 87108. Copyright 1980 by the State Medical Society of Wisconsin.

CASE REPORT. A 58-year-old dental assistant presented with a four-month history of dropping dental instruments. Review of systems revealed numerous complaints: paresthesia in her hands, burning feet, sore gums, poor concentrating ability, fatigue, headaches, and a metallic taste in her mouth. Physical examination revealed diffusely decreased vibratory sense, slight difficulty in tandem gait walking, and minimal hand tremor.

On laboratory examination the patient had normal complete blood cell count, fasting chemistry profile, electrolytes, urinalysis, B-12, folate, and a negative urinary porphyrin screen. She also had normal nerve conduction studies and a normal electrocardiogram. However, a 24-hour urinary mercury excretion was 228 μg and 119 μg on two occasions with normal less than 20 μg/24 hours.

The elevated urinary mercury levels prompted an examination of the dental office. It was discovered that a defective amalgamator was shaking fine mercury droplets on the work bench. After the amalgamator was replaced, the State Laboratory of Hygiene analyzed the mercury vapor content in the dental office and found it to be .047 mg/cu mm, slightly below the maximum allowable concentration, .050 mg/cu mm. The dentist's urinary mercury level was 35 μg/24 hours.

The patient was allowed to return to work, and over the next two months her specific symptoms abated. However, time revealed a chronic involution

depression which the patient attributed to mercury poisoning. It led the patient to retire from the dental profession and to seek compensation from the dentist.

Six months after the amalgamator was replaced, the patient's urinary mercury level had fallen to 46 μg/24 hours and one year later to 11 μg/24 hours.

DISCUSSION. The case demonstrates the nonspecific symptom complex of a patient with mercury poisoning and the problem of differentiating the toxic effects of elemental mercury from a functional disorder. The diagnosis of mercury poisoning in this patient rests upon the elevated urinary mercury levels and the resolution of her specific symptomatology with removal of the source of her exposure. Documented cases of elemental mercury poisoning typically have greater than 100 to 150 μg/24 hours of urinary mercury.[2] While cases of mercury poisoning have appeared in the dental literature, the case presented is the second to be noted in medical literature[3] read by physicians.

In the preparation of amalgam, dentists expend on the average one kilo of elemental mercury per year. At a recent dental convention greater than 50% of the dentists had above normal serum mercury levels.[1] In another study[4] urinary mercury levels were found to be abnormally high in 36 of 50 dentists. The average level was 40μg/liter and a few values almost reached toxic levels. Furthermore, greater than 10% of dental offices in Utah were found to have mercury vapor levels above the threshold limit value set by the Occupational Safety and Health Act.[5] It is likely that mercury poisoning in dental personnel is more prevalent than has been reported.

Elemental mercury poisoning is dependent upon inhalation of mercury vapor which is rapidly absorbed by the lungs. Dental personnel are exposed to mercury vapor when spillage occurs. Mercury may lie for years undetected in carpets, cracks, under desks, or in air vents, thus leading to chronic mercury vapor exposure and possible insidious toxicity. Guidelines for proper mercury hygiene have been established by the American Dental Association.[6] Commercial mercury vapor detection devices are available.[5] In addition, state health department officials will often determine mercury vapor levels at the request of physicians or dentists. It should be noted that dental patients with amalgam fillings are at no risk of elemental mercury poisoning.

Of great concern is the possible teratogenic effects of chronic "nontoxic" elemental mercury exposure to fetuses of pregnant dental personnel. Although early studies of injected inorganic mercuric chloride into the fetus, more recent studies have demonstrated that elemental mercury vapor rapidly passes the placenta and concentrates in the fetal brain.[7] However, no cases of mercury vapor induced teratogenesis have been reported. On the other hand few studies have examined mercury vapor as a fetal toxin in animals or man. It is well known that mercuric ion and organic mercury are potent teratogens.[8] In view of potential fetal injury, it has been recommended that pregnant women not work in areas where elevated levels of mercury vapor may be anticipated.[9]

SUMMARY. Physicians should consider mercury poisoning and evaluate mercury levels in dental professionals with vague, diffuse complaints of uncertain etiology. Diagnosis of mercury poisoning should demonstrate toxic urinary mercury levels (greater than 100 to 150 μg/24 hours) as well as at least partial amelioration of the symptoms with termination of exposure. Because of the nonspecific symptoms complex, mercury poisoning may be more prevalent than previously reported. Since the potential for mercury vapor toxicity exists for the fetus, pregnant dental personnel should have limited exposure to air contaminated with mercury.

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9. Siedlecki JT: Diagnosis of exposure to mercury—effect on pregnancy. *JAMA* 215:648 (Jan) 1971. ■

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Organizational SMS

Council adopts protocol for mediation, peer review

In an effort to assure due process rights for both a complainant and a physician, the SMS Council at its July 12 meeting adopted a protocol to be used for the processing of all types of mediation and disciplinary situations which may come before the Society from any source.

The protocol is available to any complainant or physician involved in future peer review activity upon request to SMS.

Other highlights of the July 12 Council meeting include:

Cut in state budget—Terry Willkom, deputy secretary of the State Department of Health and Social Services, appeared before the Council to explain the potential impact of the Governor's directive for a 4.4 percent cut in state budget. He pointed out that in Medicaid there is a 60-40 federal-state match of dollars which will cause the 4.4 percent cut to reach as high as 10 percent to make up for the loss of federal dollars. Willkom said it was the current intention of the Department to apply the 4.4 percent cut across the board to all Medicaid providers, both institutional and non-institutional. Specifics on the implementation of the cut were expected to be announced about August 1.

The Executive Committee of the Council and the Physicians Alliance Commission will be monitoring the Governor's budget-cutting process very closely in the next few weeks to prepare an appropriate response when the full facts are known. (Watch future issues of MEDIGRAM)

SMS sued by WPS/Pension Plan—Wisconsin Physicians Service (WPS) has brought suit in federal court against the State Medical Society and the SMS Employees Pension Plan Managing Committee, as well as the First Wisconsin National Bank, Madison. WPS is seeking $175,000 plus costs in a dispute about the distribution of the SMS Pension Plan assets required as a result of the 1979 spin-off of WPS from the SMS Pension Plan. SMS, on advice of its actuary, had set aside $1,329,525 (invested through First Wisconsin) to pay future pension benefits for SMS employees already retired or who have terminated with future pension rights. Many of these employees were assigned to WPS activities prior to 1978.

WPS alleges the Society's Pension Plan Managing Committee, composed of Doctors John J Foley, Menomonee Falls; William A Nielsen, West Bend; Wayne J Boulanger, Milwaukee; Cyril M. Hetsko, Madison; Joseph M Jauquet, Ashland; Jung K Park, Wisconsin Rapids; and Irvin L Schroeder, Plymouth, has "arbitrarily, capriciousiy and in bad faith" set aside $200,000 more than necessary to fund these pension benefits. Since various negotiation efforts have failed, SMS Pension Plan is responding to the legal action in order to protect the interests of its pension beneficiaries, including past employees who were associated with WPS.

Premarital physical examinations—The Council reviewed allegations that physicians are inappropriately doing "complete physicals" on persons who seek only a premarital physical examination as that is defined by statute. The Council believes that the state registrar's office, county clerks, and the public are generally misinformed about the requirements of the state law. The statute clearly requires physicians to certify that they have given individuals a "thorough examination" to assure that they are free from "all venereal disease." This obviously requires an office visit and Wassermann or other standard blood test for syphilis. This is not considered a complete physical examination by physicians. It simply complies with the statute. Other laboratory tests may be indicated as a result of the office visit. Allegations that physicians are requiring complete physical examinations have not been substantiated by either the state registrar or the county clerks. A committee including representatives of the SMS and government are reviewing the law to determine whether it should be changed, and if so, how. Until the law is changed in the 1981 session of the Legislature, physicians must continue to meet the requirements of a thorough examination as outlined above, the Council concluded.

Notification to physicians of complaints to Medical Examining Board—Several physicians have complained to the State Medical Society that the Medical Examining Board refuses to inform them of a complaint it has received from a patient and conducts substantial investigation without advising the physician, although knowledge of the investigation quickly becomes public. Legal opinion from Society counsel indicates that the law does not require the Board to reveal complaints until the Board's own investigation provides sufficient cause for formal action. The Council noted that it must so advise Society members, but it also requested that attempts be made to have the Medical Examining Board reconsider its position and to seek an opinion from the Attorney General.

Membership—Following an in-depth presentation of facts concerning the number, specialty, location, and other information about nonmembers of the Federation (county-state-AMA), it was agreed that the Council would accept primary responsibility for membership recruitment and retention planning and implementation with staff coordination through Mike Brozek who has been reassigned from his position as legislative coordinator to directing the public affairs efforts of the Society. Specific strategies in this membership effort will be presented at the September 27 Council meeting. Thus fus the Society has gained 130 new members.

Review of Medical Practice Act—The Council authorized establishment of an ad hoc committee to undertake a study of the Medical Practice Act and statutes related to allied health personnel consistent with a Wood County Medical Society resolution adopted by the House of Delegates in March. The committee is to include Doctors Michael Mehr, Marshfield; Carl Eisenberg, Milwaukee; and Theodore Fox, Antigo, all from the Governmental Affairs Commission, with additional representation to be appointed by the chairman of the Council, Dr Darold A Treffert, Fond du Lac.

Medical Advisory Committee—The Council authorized the nomination of up to nine physicians to constitute a formal advisory committee to Dr Alfred Dally, Madison, the medical advisor to the Wisconsin Medical Assistance (Medicaid/Title 19) Program. This committee would consider such matters as medical benefits under T-19, appropriateness of procedures, outdated or experimental procedures, and procedures for which payment would either be prohibited or require prior authorization.

Leadership conference—The Council authorized a leadership conference for county and specialty medical society officers for the fall of 1980, to be held in Milwaukee or Madison depending upon facilities. (Watch future issues of MEDIGRAM)

Patient access to medical records—The Council directed that a statement summarizing the recently enacted law on patient right of access to medical records be distributed to all members along with a copy of the law and the suggestion that the June 1980 BLUE BOOK article on retention of medical records be reviewed by physicians and that the statement on the new law be utilized by posting in physicians' offices or otherwise made available to patients as a means of compliance.

EPSDT—The Council endorsed consultation with county medical societies in which screening for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) of eligible T-19 children has been unsuccessful, and suggested that serious consideration be given to a Wisconsin Health Care Review, Inc (WHCRI) proposal as a pilot project to pay physicians directly through WHCRI for screening services, thus avoiding the problems of T-19 paperwork.

Public health—The Council approved, subject to further editorial revisions, a report on the Public Health System in Wisconsin and recommendations to the Governor in that regard. Copies of the report are available from SMS offices.

Physician distribution—The Council approved a report on Physician Distribution in Wisconsin. After final editing and presentation of the report to the Governor, copies will be available from SMS offices.

Appointments—The Council approved the following appointments:

SMS-WNA Joint Practice Committee—Doctors Glenn Franke, Milwaukee (continuing member); James Tydrich, Richland Center; John Mullooly, Milwaukee.

Commission on Mediation and Peer Review—Doctors Albert H Adams, Milwaukee; Domenick S Bruno, Milwaukee.

Committee on Maternal and Child Health—Dr Gary Gutcher, Madison.

Commission on Governmental Affairs—Dr M Thomas Chemotti, Cedarburg (representing Section on Ophthalmology).

Commission on Health Planning—Doctors James C Allen, Madison (Section on Ophthalmology); Gary R Gutcher, Madison (Wisconsin Chapter, American Academy of Pediatrics); J Brent Kooistra, Madison (Wisconsin Allergy Society); Kenneth R Kubsch, Green Bay (Section on Internal Medicine); and Hal B Ridgway, Madison (Section on Dermatology).

CES Foundation—The Board of Trustees of the Charitable, Educational and Scientific Foundation of the State Medical Society, also meeting on July 12, approved a membership and fund-raising program to enlist support for the Foundation and the Fort Crawford Medical Museum in Prairie du Chien. All physicians as well as many other individuals, corporations, and foundations will be solicited in this effort. A special report on the first 25 years of the Foundation's activities as well as a guide to gifts, bequests, and trusts is being prepared for widespread distribution. SMS officers and councilors are members of the CESF Board of Trustees. ■

SMS committee to study care of chronically mentally ill

The SMS Committee on Mental Health, under the chairmanship of Dr Charles Landis, Milwaukee, is undertaking development of a comprehensive issue paper on the care of the chronically mentally ill (CMI) in preparation for the next legislative session.

The committee considers the latest mental health law revisions (Ch 336, Laws of 1979) as a step forward, but inadequate to deal with a number of issues such as the definition of "dangerousness" as a criterion for involuntary commitment, funding priorities, community care of CMI patients, and the role of physicians and other personnel with CMI. Physicians having suggestions for the committee are urged to contact Doctor Landis through the Committee on Mental Health at SMS offices in Madison. ■

SMS report concludes: No physician shortage

The State Medical Society of Wisconsin has concluded that Wisconsin will not face a statewide physician shortage in the next 10 years but that scattered rural and urban communities will have difficulty finding adequate numbers of primary care physicians.

In a special report to Governor Dreyfus on physician distribution in Wisconsin, the Society said that the number of active physicians in Wisconsin has increased more rapidly than the state's population in recent years contributing to a physician-to-population ratio of 1 to 720. The Society said this ratio "represents a satisfactory number of physicians and is evidence that a serious statewide physician shortage does not exist in Wisconsin."

The Society emphasized that in spite of the increasing number of physicians, appropriate distribution of physicians remains a problem. "There are physician deficiency areas in the state where more physicians are needed, particularly those who provide primary care," it concluded. "It remains a fact that some people living in rural and urban areas do not have ready access to a physician for primary medical care."

The Society cited data from federal and state government sources identifying 49 communities where the primary care physician-to-population ratio was unsatisfactory.

The report was the product of a year's study by a State Medical Society committee chaired by Kermit Newcomer, MD of LaCrosse.

The Society singled out the National Health Service Corps (NHSC), a federally funded program to help medically underserved areas, as ineffective and contributing to the exodus of Wisconsin-trained primary care physicians to other states.

Under the program medical students receive financial support in return for a commitment to practice medicine in a federally designated primary care physician shortage area.

Because of rising tuition, more Wisconsin medical students are making commitments to the NHSC program than there are available NHSC practice sites in Wisconsin, according to the Society's report.

In its report, the Society made 13 recommendations aimed at getting more physicians to locate practice in deficiency areas. They include:

- Increasing the number of applicants and admissions from medically underserved populations to the UW Medical School and the Medical College of Wisconsin.
- Providing sufficient state budget support to both medical schools so that in-state admission rates remain high.
- Increasing affirmative action admission efforts so that minority enrollment at both medical schools are representative of the general population.
- Reevaluating curricula at both medical schools to assure they provide adequate exposure to medical problems unique to rural areas and other medically underserved populations.
- Keeping tuition at both medical schools as low as possible and linking any increases to a loan forgiveness program.
- Investigating the need for more primary care residency programs.
- Assuring equitable physician fee reimbursements between urban and rural areas for the same or similar medical services.
- Revising federal regulations on the designation of NHSC sites so that NHSC physicians can be placed in state defined deficiency areas as well as federally designated shortage areas.
- Immediate implementation of the state's new student loan forgiveness program, and investigation of the potential of establishing a State Health Service Corps utilizing state GPR dollars for funding.
- Developing a rural health support system to provide physicians in isolated areas with opportunities for continuing medical education, office management assistance, insurance and other practice benefits.
- Reconsideration of all health planning decisions and strategies that call for the closing of rural hospitals.
- Developing a centralized physician placement service to help communities assess medical needs and recruit physicians to meet them.

The Medical Society study was conducted by Doctors Newcomer, LaCrosse; John Renner, Madison; Paul Rosenfeld, Milwaukee; John Peters, Fond du Lac; Martin Janssen, Adams; Henry Goldberg, Milwaukee; Jan Erlandson, Monroe; John Kief, Rhinelander; Darold Treffert, Fond du Lac, the Society's immediate past president; and Russell Lewis, Marshfield, the Society's president.

As reported elsewhere in this issue, the Society's Council, at its July 12 meeting, approved the report for presentation to the Governor. The report has been circulated to SMS councilors and officers, county medical societies, Health Policy Council, state government officials, and health agencies, and is available to the membership upon request to the SMS offices in Madison: 257-6781 or toll-free 1-800-362-9080. ■

Major reform for public health system proposed

A major reform of the state's public health system is proposed by the State Medical Society of Wisconsin in a special report delivered to Governor Dreyfus.

The report, prepared at the suggestion of Governor Dreyfus, alleges that failure to act may impair the delivery of necessary public health services to Wisconsin citizens.

The State Medical Society contends that public health has a "low priority" in state government, lacks

adequate state and local fiscal support, and is the victim of "steady erosion" over the past decade.

In releasing the report Robert Carlovsky, MD, Fond du Lac, chairman of the Society's study committee said, "The health of our citizens is one of the state's greatest assets and should be a top priority with government, business, and labor as well as physicians."

At the state level the report proposes creation of a new Division of Public Health in the Department of Health and Social Services which would consolidate health functions now performed by four other state departments. A separate Division of Health Regulation and Financing would be created to take over Medicaid health planning, needs review, and quality compliance which are a part of the present Division of Health.

At the local level the report proposes a county, city-county, or multiple county network of "full service" public health units to replace the numerous local agencies currently performing various levels of services. The new units would be funded by local government with state general revenue support up to $3 per capita, which could require approximately $14,000,000 in new state dollars. "Full service" would include community, environmental, and mental health services.

Also recommended are:

1. A health professional trained in public health administration to head the proposed Division of Public Health.
2. Consolidation into the Division of Public Health of air and water quality and solid waste programs now in the Department of Natural Resources; crippled children and cystic fibrosis program now in the Department of Public Instruction; meat, food and product safety programs now within the Department of Agriculture, trade and consumer protection; and occupational health and safety programs now under the Department of Industry, Labor and Human Relations.
3. Improved Division of Public Health responsibility between state and local health units.
4. Better planning and coordination of all public health services.
5. Improved communications between state agencies which have public health functions.
6. Less reliance on federal dollars for state government public health programs.
7. A graduate program in public health administration at the University of Wisconsin.

The Society study committee was composed of Doctors Carlovsky, Fond du Lac; Thomas Belson, Waukesha; Richard Bibler, Menomonee Falls; Richard Biek, Waupaca; Theodore Fox, Antigo; James Glasser, LaCrosse; George Handy, Madison; Guenther Pohlmann, Milwaukee; Ralph Suechting, Neenah; John Peters, Fond du Lac; and Russell Lewis, Marshfield, the president of the State Medical Society.

The Society expects to seek statewide support for its proposals, including legislation in the 1981 session.

As reported elsewhere in this issue, the Society's Council, at its July 12 meeting, approved the report and recommendations to the Governor. The report has been distributed to SMS councilors and officers, county medical societies, Health Policy Council, state government officials, and other health agencies, and is available to the membership upon request to the SMS offices in Madison: 257-6781 or toll-free 1-800-362-9080. ■

SMS annuity unit value: $3.17

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $3.17 as of June 30, 1980. This compares with $3.08 at May 30, 1980 and $2.92 at April 30, 1980. ■

CES FOUNDATION

CONTRIBUTIONS—JUNE 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1980.

Restricted

St Croix Falls Clinic; Falls Medical Group; John C Honish, MD; Roger S Strube, MD; Medical Associates-Baraboo; Door County Medical Center; Lloyd Steffan, MD; David P Losh, MD; Wisconsin Rural Rehabilitation Corp; Wisconsin Physicians Service; Riverwood Clinic; Sauk Prairie Memorial Hospital; Osseo Medical Center; Elmbrook Hospital—*Medical Student Summer Externship Program*

Pierce-St Croix County Medical Society—*Museum of Medical Progress*

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Membership Donations—*Aesculapian Society*

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Marcella Herfel; State Medical Society—*Thomas Smithberger*

Dr-Mrs Robert T Schmidt—*Mrs Osen; Carl J Mraz; Marilyn Blakesley; Mrs Stannard*

State Medical Society—*Clarence H Buckley, MD; Charles M Balliet, MD; Phillip A Quilling, MD; Rodney J Gray, MD; Nathan S Davies, MD; Vernon J Hittner, MD; Joseph A Caton, MD; Wilfred Seng, MD; Norbert Enzer, MD; Matthew A McGarty, MD; Joseph A Freeman, MD*

Mr-Mrs Earl R Thayer—*Alejandro Guansing, MD; Donald W Gjeston; Thomas Smithberger; Scott A Schweers*

Dr JS Huebner; Romona Huebner—*Mr Charles Redford*

Dr-Mrs Leslie Jones—*Mrs John McCullough*

Naomi G Hammes—*Elsie Wright* ■

AMA annual convention highlights

Actions of the AMA House of Delegates, which met July 20-24 in Chicago, were reported in the August 1/8 issue of *American Medical News*. These actions involved some 250 reports and resolutions which were reviewed during the daily sessions of the Wisconsin Delegation consisting of Doctors Henry F Twelmeyer and DeLore Williams of Milwaukee, Gerald J Derus and John K Scott of Madison, Patricia J Stuff of Bonduel (delegates); and Doctors Richard W Edwards of Richland Center, John R McKenzie Jr of Oshkosh, Cornelius A Natoli of LaCrosse, John D Riesch of Menomonee Falls, Warren H Williamson of Racine (alternate delegates); and President Russell F Lewis, Marshfield; President-elect Albert J Motzel Jr, Waukesha; and George F Collentine, Milwaukee, member of the AMA Council on Medical Service.

Among the items that generated a lot of attention by the media are a report on HMOs, the new Principles of Medical Ethics, and chiropractic. In order that the membership receives accurate information on the AMA actions as adopted, the new Principles and those recommendations on HMOs actually adopted are being reproduced here.

New Principles of Medical Ethics

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences with the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Health Maintenance Organizations (HMOs)

Recommendations of the AMA Council on Medical Service adopted by the AMA House of Delegates:

(1) That approval of the concept of neutral public policy and fair market competition among all systems of health care delivery continue to be AMA policy, with the potential growth of HMOs being determined not by federal subsidy, preferential federal regulations, and federal advertising promotion, but by the number of people who prefer this mode of delivery;

(2) That the AMA continue to recognize that no single pattern of health care delivery is necessarily suited to all patients or to all physicians, and that the presence of multiple alternative delivery systems will enable both patients and physicians to exercise a true choice;

(3) That the AMA continue to express its concern that high standards of quality, adequate physician-patient ratios, and continuity of personal care be maintained in all modes and systems of health care delivery;

(4) That individual physicians and groups of physicians become better informed about the pros and cons of establishing or participating in an HMO if interest in this form of health care delivery is present in their community;

(5) That the AMA continue to provide information to medical societies and physicians concerning HMOs;

(6) That the AMA encourage research in those areas of HMO performance which have been identified as needing further study; for example, whether factors leading to apparent HMO cost-effectiveness are unique to the HMO pattern or whether they may be applicable to other forms of practice . . .

A recommendation "that the HMO approach to health care delivery be recognized as one which may result in care for enrollees at a lower total cost than for comparable groups in other health care delivery systems, whether the group, staff, or IPA model HMO is considered," was referred back for further study.

Study of chiropractic

The AMA House adopted a resolution "that the AMA urge that an appropriate (federal) agency fund an independent and impartial study to evaluate the efficacy and safety of chiropractic." ■

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Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of July 3, 1980

NEW MEMBERS

County Medical Society

DANE

Doezema, David, 4114 Mandan Crescent, Madison 53711 (1947, Regular, Internal Medicine, Certified)

Evans, Joseph J, 5510 Meadowood Dr, Madison 53711 (1951, Resident, Internal Medicine)

Musser, W Eugene, 202 South Park St, Madison 53715 (1946, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)

DODGE

Rawlins, Steven J, 138 Front St, Beaver Dam 53916 (1943, Regular, Diagnostic Radiology/Radiology, Certified-R)

JEFFERSON

Tonn, Elizabeth C, 1173 West Main St, Whitewater 53190 (1950, Regular, Family Physician, Certified)

MANITOWOC

Rauschenberger, Thomas R, 600 York St, Manitowoc 54220 (1950, Regular, Family Physician)

MARATHON

Bodemer, Steven E, 800 Third St, Wausau 54401 (1946, Regular, Pathology, Certified)

MILWAUKEE

Abram, Stephen E, 8700 W Wisconsin Ave, Milwaukee 53226 (1944, Regular, Anesthesiology, Certified)

Bhala, Ram Parvesh, 2900 W Oklahoma Ave, Milwaukee 53215 (1935, Regular, Physical Medicine and Rehabilitation, Certified)

Bragg, Everett C, 730 East Sylvan Ave, Whitefish Bay 53217 (1913, Regular, Orthopedic Surgery, Certified)

Christianson, Randolph P, 2414 North 60th St, Milwaukee 53210 (1947, Regular, Emergency Medicine—General Surgery)

Liang, Jyh-Chwen, 606 W Wisconsin Ave, Milwaukee 53203 (1943, Regular, Obstetrics and Gynecology)

Max, Martin H, 950 North 12th St, Milwaukee 53233 (1941, Regular, General Surgery, Certified)

Nierengarten, Gregory, M, DO, 3821 S Howell Ave, Milwaukee 53207 (1947, Regular, Family Physician, Certified)

WASHINGTON

Bickford, Lester C, 406 Weis St, Allenton 53002 (1943, Regular, Family Physician, Certified)

WINNEBAGO

Boyle, John S, 510 Doctors Court, Oshkosh 54901 (1944, Regular, Orthopedic Surgery, Certified)

Elisberg, John M, 650 Doctors Court, Oshkosh 54901 (1949, Regular, Internal Medicine, Certified)

Romond, David H, 510 Doctors Court, Oshkosh 54901 (1946, Regular, Orthopedic Surgery/Hand Surgery)

CHANGE OF ADDRESS

(Does not include those within a city)

COLUMBIA-MARQUETTE-ADAMS

Jones, Weston W, Portage, to 4913 Chalet Garden Rd, Apt 204, Madison 53711

DANE

Finlay, Jonathan L, Madison, to 315 Alta Vista Ave, Los Altos, CA 94022

Godfrey, Charles B, Oregon, to 1226 Milton St, Madison 53715

NEWS YOU CAN USE

WISCONSIN HOSPITAL ASSOCIATION ANNUAL CONVENTION, OCTOBER 23-24. The WHA's annual convention at Lake Lawn Lodge in Delavan, October 23-24, will have as its keynote speaker Jack Anderson, the political columnist.

STATE PUBLIC HEALTH SERVICES THREATENED BY FEDERAL CUTBACKS. A major gap in Wisconsin's Division of Health programming is likely after September 30 (the end of the federal fiscal year) according to state health officials. Speaking to the State Health Policy Council recently, Robert Durkin, the Policy Council's secretary, reported that federal 314(d) funds will virtually cease after September 30. These funds currently support 31 positions including some in environmental health, laboratory of hygiene, public health nursing, and some support to city and county health departments. Wisconsin had $1.6 million in 314(d) monies for 1979-80. No provision has been made for the state to replace these dollars and it seems unlikely to occur before the start of the state's new fiscal year in July 1981, Durkin indicated. The State Division of Health has an annual budget of about $795,000,000 of which 95 percent is for operation of the Medicaid program. The balance (5 percent) totals about $40,000,000 and supports all other Division of Health operations and programs, including the $1.6 million scheduled for cut-off in October. ■

Grab, David S, Madison, to c/o GVGHA, 800 Carter St, Rochester, NY 14604
Kolar, Britton W, Madison, to 816 Wisconsin Ave, Lake Geneva 53147
Lloyd, Ricardo V, Madison, to 430 East 67th St, Apt 9M, New York, NY 10021
Miller, Steven A, Middleton, to 501 Walnut Springs, Dayton, OH 45419

FOND DU LAC
Jones, Leslie E, Fond du Lac, to 807 Oregon St, Apt B, Weslaco, TX 78596

FOREST
Ovitz, Ernest G, Englewood, FL, to 5159 E Silver Lake Rd, Laona 54541

LACROSSE
Edwalds, Robert M, LaCrosse, to 695 N Kellogg St, Galesburg, IL 61401

LINCOLN
Sanan, Omer K, Tomahawk, to 621 E Walnut St, Green Bay 54302

MANITOWOC
Kancayappan, Sivakami, Omaha, NE, to 601 Reed Ave, Manitowoc 54220
Curtiss, Carl M, Manitowoc, to 3250 Aimwick, Upper Arlington, OH 43221

MARATHON
Blumen, Louis J, Wausau, to 14 Equinox Ct, Apt 2B, Delmar, NY 12054

MILWAUKEE
Bachhuber, Edward A, Milwaukee, to 607 River Dr, Mayville 53050
Biek, Richard W, Waupaca, to 841 N Broadway, Milwaukee 53202
De Cock, David G, Long Beach, CA, to 1313 Fish Hatchery Rd, Madison 53715
Fuhrmann, Donn D, Milwaukee, to 1420 Algoma St, New London 54961
Matz, Dan, Milwaukee, to 13060 Meadowlark Ave, Granada Hills, CA 91344
Redlin, Russell R, Indo, CA, to 6440 Briarwood Lane, Waterford 53185
Reeder, Tilden B, Milwaukee, to 6310 Alvarado Court, San Diego, CA 92120
Schulz, Caryn I, Wood, to 1759 Drummond St, Eau Claire 54701

PIERCE-ST CROIX
Bhatnagar, Vinod K, New Richmond, to 5711 Oren Ave North, Stillwater, MN 55002
Mc Mahon, Arthur E, Menomonie, to 501 S Kentucky Ave, Mason City, IA 50401

SHEBOYGAN
Johnson, Rodney C, Sheboygan, to Dept of State USA, M/Med Rm 2906, Washington DC 20520

TREMPEALEAU-JACKSON-BUFFALO
Thurow, Roland M, Black River Falls, to 9518 N 46th St, Phoenix, AZ 85028

WAUKESHA
Stein, Ronald W, Waukesha, to PO Box 486, Pewaukee 53072

WAUPACA
Dazo, Alfredo S, King, to 1100 Parkview Dr, Roseville CA 95670

WOOD
Frederick, T Bayard, Marshfield, to 789 S Seventh Ave, Park Falls 54552

COUNTY-TO-COUNTY TRANSFER
Oconto to Milwaukee: Eckstrom, Philip T, 3225 Cullen Dr, Brookfield 53005
Waukesha to Milwaukee: Herrington, Roland E, 2511 Broken Hill Court, Waukesha 53186

DEATHS
Elmer B O'Leary, Milwaukee County, 1980
Enzer, Norbert, Milwaukee County, May 30, 1980
Guansing, Alejandro R, Milwaukee County, May 31, 1980
Waxman, Saul I, Milwaukee County, June 2, 1980
Graver, Rex E, Chippewa County, June 6, 1980 ■

Obituaries

◇ County, State, AMA Members

◇ **Norbert Enzer, MD,** 78, Milwaukee, died May 30, 1980 in Milwaukee. Born Oct 27, 1901 in Montreal, Canada, Doctor Enzer graduated from McGill University, Canada, in 1923 and served his internship in Binghamton, New York. Following his residency at Michael Reese Hospital, Chicago, he joined the medical staff of Mt Sinai Hospital, Milwaukee, as pathologist and director of laboratories. Doctor Enzer was regarded as a leading pathologist in both national and international circles. He provided consultative services to the state and was a frequent lecturer before medical and legal groups. He retired in 1968. He was a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are his widow, Fannie; one daughter, Jean Nussbaum, Highland Park, Ill, and one son, Dr Norbert, chairman of the Department of Psychiatry at Michigan State University in East Lansing.

◇ **Alejandro R Guansing, MD,** 42, Brookfield, died May 31, 1980 in Brookfield. Born Nov 7, 1937 in Manila, The Philippines, he graduated from the University of the Philippines College of Medicine in 1963. He served his internship and residency at Albert Einstein Medical Center, Philadelphia, and Henry Ford Hospital, Detroit, respectively. An assistant professor of medicine at the Medical College of Wisconsin, Doctor Guansing also was associate director of Gerentology/Geriatrics at the Medical College and a staff physician in the endocrine—metabolic section at the Veterans Administration Medical Center, Wood, Wis. He was president of the Philippine Medical Society of Wisconsin and a fellow of the American College of Physicians and the Royal College of Physicians of Canada. Surviving are his widow, Lilian; and four children, Benjamin, Raymond, Jocelyn and Alan.

◇ **Saul I Waxman, MD,** 74, Glendale, died June 3, 1980 in Milwaukee. Born Oct 7, 1905 in Rumania, Doctor Waxman graduated from Marquette University School of Medicine in 1929. He served his internship at Mount Sinai Hospital, Milwaukee, and served on the medical staff and the executive boards of Mount Sinai and Family Hospital for many years. Surviving are his widow, Ethel; two daughters, Mrs Maxa dai of Madison, and Miss Dana lin Waxman of Glendale.

◇ **Rex E Graber, MD,** 81, Chippewa Falls, died June 6, 1980 in Chippewa Falls. Born Apr 5, 1899 in Parker, South Dakota, Doctor Graber graduated from Rush Medical College in 1923 and served his internship at Kings County Hospital, Brooklyn, New York. He practiced in Bismark, North Dakota, and Stanley, Wis, before he moved to Chippewa Falls in 1931. He was the district health officer for District 7 of the Wisconsin State Board of Health, Eau Claire, where he served from 1951 until he retired in 1968. Surviving are his widow, Lois; and two daughters, Mrs Marilyn Dunphy, Roswell, Ga, and Mrs Susan Maitland of Chippewa Falls. ■

County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

DANE: Dane County Medical Society has donated $500 to the Aesculapian Society of the CES Foundation specifically for "restoration, maintenance, and promotion of the medical museum at Prairie du Chien."

GREEN: New officers of the Green County Medical Society for the year 1980-81 are as follows: MDs Geoffrey L Tullett,* Monroe, president; and George E Breadon,* Monroe, secretary.

MANITOWOC: The following MDs recently were elected to office of the Manitowoc County Medical Society. They are as follows: Barry V Bast,* president and Steven D Driggers,* secretary. Both of the physicians are from Manitowoc.

WAUKESHA: New officers of the Waukesha County Medical Society for the year 1980-81 are as follows: MDs Lee M Tyne,* Brookfield, president; Michael R McCormick,* Waukesha, president-elect; Matthew A Meyer,* Pewaukee, secretary; Richard C Zimmerman,* Menomonee Falls, treasurer; and Robert H Herzog, Elm Grove, executive secretary. On the Board of Censors are MDs Gary O Iverson,* Menomonee Falls, chairman; Thomas J Dougherty,* Waukesha; and James E Dall,* Waukesha. The Grievance Committee consists of MDs Thomas A Hofbauer,* Menomonee Falls, chairman; LaVerne H Herman,* Waukesha; and Walter E Gager,* Waukesha. Delegates to the State Medical Society are as follows: MDs Wayne H Konetzki,* Waukesha; Kenneth J Dempsey,* Menomonee Falls; Ronald J Darling,* Waukesha; G Daniel Miller,* Oconomowoc: John D Riesch,* Menomonee Falls; and John A Harris,* Waukesha. Alternate delegates are MDs Robert L Warth,* Waukesha; Charles E Holmburg,* Hubertus; Michael C Janowak,* Oconomowoc; Mark J Popp,* Brookfield; John S Blackwood,* Brookfield; and Gerald L Harned,* Waukesha. Chairman of the county society's Physicians Alliance Committee of the State Medical Society is LaVerne H Herman,* Waukesha. All of the physicians listed comprise the executive committee. ■

★

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Specialty Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Wisconsin Society of Internal Medicine and American College of Physicians will hold a joint meeting September 11-13 at Devil's Head Resort at Merrimac, Wisconsin. The first day (Thursday) will lead off with a tennis tournament and a golf tournament. Registration desk for the meeting opens at 4:00 pm. On Friday the meeting opens at 8:15 am with a welcome and introductory remarks by Michael J Mally, MD,* Hartford, president, Wisconsin Society of Internal Medicine; and Charles L Junkerman, MD,* Milwaukee, Governor for Wisconsin, American College of Physicians.

The morning program is entitled "Antibiotic Therapy for the 80s" with Michael W Rytel, MD, Medical College of Wisconsin, Milwaukee, as moderator. The following papers will be presented.

"New Treatment for Lower Respiratory Tract Infections" by Robert E Van Scoy, MD, Department of Medicine, Mayo Clinic Graduate School of Medicine.

"Antibiotics in Vivo and In Vitro: Why Some Antibiotics Don't Work in Your Patient" by Leon D Sabath, MD, FACP, Department of Medicine, University of Minnesota School of Medicine.

"Manipulation of the Cephalosporins for the Future" by Martin J Raff, MD, FACP, Department of Medicine, University of Louisville School of Medicine.

"Prophylactic Antibiotic Therapy" by Dennis G Maki, MD, FACP, Department of Medicine, University of Wisconsin School of Medicine.

The American College of Physicians luncheon will start at 12:30 pm with introductory remarks by Charles L Junkerman, MD, FACP,* ACP Governor for Wisconsin.

The Friday afternoon program is entitled "Neurology for the Internist." The following papers will be presented:

"The Middleton Memorial Lecture—Dementia" by Jeremiah A Barondess, MD, MACP, Past President of the American College of Physicians.

"Myasthenia Gravis and Myasthenic Syndrome" by Frank M Howard, Jr, MD, Department of Neurology, Mayo Clinic, Mayo Graduate School of Medicine.

"Inflammatory Myopathies" by David B Frens, MD,* Department of Neurology, Marshfield Clinic.

"Polyradiculopathies" by James W Albers, MD, Department of Neurology, University of Michigan School of Medicine.

A social hour will precede the WSIM/ACP Annual Banquet Friday evening.

At 8:00 am Saturday there will be a WSIM Breakfast and Business Meeting. Michael J Mally, MD,* Hartford, president of WSIM, will preside. The speaker will be John F Farrington, MD, Boulder, Colorado, president of American Society of Internal Medicine.

A socioeconomic program will start at 9:30 am Saturday with Russell A Quirk, MD,* Racine, as moderator. Doctor Quirk is a Council member of the WSIM. Its title: "Prepaid Health Care: The PROs and CONs." Speakers will be Mervin Shalowitz, MD, Skokie, Illinois, trustee of American Society of Internal Medicine; and Russell F Lewis, MD,* Marshfield, president of the State Medical Society of Wisconsin. These speakers will focus on Individual Practice Associations (IPAs) and Health Maintenance Organizations (HMOs), and the increasing trend toward prepaid healthcare and its effect on physicians.

Further information may be obtained from the Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202. ■

NEWS YOU CAN USE

HOSPITAL RATE REVIEW PROPOSALS IMPACT MEDICAL CARE. Recent allegations by the Legislative Audit Bureau that the Wisconsin Hospital Rate Review Program is a failure (denied by WHA and Blue Cross) have prompted proposals from the State Department of Health to "control" patient admissions, intensity of medical services, use of services, length of stays, and the technology of medical care. At first blush it appears that a hospital, and therefore the Rate Review Program, will be required to make medical judgments. The Physicians Alliance Commission of SMS will be reviewing the Audit Bureau report as well as closely monitoring these proposed new regulations to inform the membership and intervene on behalf of physicians and patients as necessary. For further information physicians may wish to contact Brian Jensen, director of the Physicians Alliance, at SMS offices in Madison: 257-6781 or toll-free 1-800-362-9080. ■

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

John Van Tuyl, MD, Reedsburg, recently opened his medical practice at the Reedsburg Area Medical Center. Doctor Van Tuyl, a general and vascular surgeon, graduated from the University of Iowa Medical School. He served his internship at Hennepin County Hospital in Minneapolis, Minn, and practiced general medicine in Cedar Rapids, Ia. After extensive training in surgery in Des Moines, Ottawa, Ontario and Lockport, NY, Doctor Van Tuyl became certified by the American Society of Gastrointestinal Endoscopy.

John C Gallagher, MD, recently became associated with the medical staff of the Dousman Clinic, Dousman. Doctor Gallagher graduated from Loyola University Stritch School of Medicine in 1976 and served his internship training at the University of Southern California, Los Angeles County Hospital, and at Loyola University Medical Center.

Douglas R Meyer, MD, Superior, recently became a member of the Superior Clinic in the Department of Obstetrics and Gynecology. Doctor Meyer graduated from Georgetown University School of Medicine, Washington, DC, and completed his residency at the Albany Medical Center Hospital in Albany, New York.

Lance Zernzach, MD, Omro, recently opened his medical practice at the Omro Medical Clinic. He graduated from the University of Wisconsin Medical School, Madison, and served his residency at St Mary's Hospital in Madison. Prior to joining the Omro Medical Clinic, Doctor Zernzach had practiced in Mauston. He is affiliated with the Mercy Medical Center, Oshkosh.

Melvin Rosen, MD, Madison, has become associated with the Waunakee Community Medical Clinic, Waunakee. A 1977 graduate from Miami Medical School, Doctor Rosen recently completed his family practice residency at the University of Wisconsin Hospitals in Madison.

Pat Chan, MD, recently began her medical practice at the Greater Deerfield Health Center. She graduated from Mahidol University Medical School in Bangkok, Thailand, and served a rotating internship and one year of pediatric residency in Bangkok. She also served an internship at the graduate hospital of the University of Pennsylvania followed by a residency in internal medicine at St Mary's Hospital, Rochester, NY. Kris Chan, MD, husband of Doctor Pat, is a neurosurgeon associated with the Madison Neurological Center.

Joseph E Geenen, MD,* Racine, has been reelected treasurer of the American Society of Gastrointestinal Endoscopy, whose headquarters are in Boston, Mass. Doctor Geenen has served as treasurer since 1977. He is the appointed director and coordinator of the Digestive Disease Center and GI Fellowship Training Program at St Luke's Hospital, Racine. He also is on the medical staff of St Luke's and St Mary's hospitals while providing consultative services at Trinity Memorial Hospital in Cudahy, Milwaukee County Medical Complex, and Veterans Administration Hospital in Wood. A 1960 graduate of Marquette University School of Medicine, Doctor Geenen currently is clinical professor of medicine at the Medical College of Wisconsin, chief of medicine at St Luke's Hospital, Racine, and councilor of the Wisconsin Society of Internal Medicine.

Doctor Geenen

Edwin Ferguson, Jr, MD, recently became associated with the Waunakee Community Medical Clinic, Waunakee. He graduated from the George Washington University School of Medicine, Washington, DC, in 1974. He served his residency at the University of Wisconsin Hospitals, Madison. Doctor Ferguson previously had practiced in Barboursville, W Va.

Robert M Green, MD,* LaCrosse, recently was chosen a fellow in the American Society for Cardiac Angiography. Doctor Green, a cardiologist and internal medicine specialist, has been a member of the Gundersen Clinic medical staff since 1964.

Allen D Belden, MD, New London, recently completed Board exams in Psychiatry and Neurology. A practicing psychiatrist with Appleton Psychiatric Associates, he is the medical director of the Stress Management Laboratory at St Elizabeth Hospital.

George L Hess, MD, Sheboygan, recently was certified by the American Board of Anesthesiology. He has been a member of the medical staff at St Nicholas Hospital, Sheboygan, since 1979. He graduated from the Medical College of Wisconsin, Milwaukee, where he also completed his residency. He is a member of the American Society of Anesthesiology and is an assistant clinical professor at the Medical College of Wisconsin.

James W Hoftiezer, MD, Manitowoc, recently joined J Lawrence Stoune, MD, in the practice of internal medicine and gastroenterology. Doctor Hoftiezer graduated from the University of Illinois Medical School, Chicago, and completed his internship and residency at the University of Missouri Medical Center in Columbia.

Frederick J Boehm, MD, Stevens Point, recently became associated with John A Picconatto, MD,* in the practice of obstetrics and gynecology. Doctor Boehm graduated from Southern Illinois University School of Medicine where he also completed his residency. He is a junior fellow in the American College of Obstetrics and Gynecology.

Lawrence P Peterson, MD, West Salem, recently became a member of the Gundersen Clinic, Ltd. Doctor Peterson graduated from the University of Minnesota Medical School and served his psychiatry residency at the Mayo Graduate School of Minnesota, Rochester. Prior to joining the Clinic, Doctor Peterson was a clinical instructor at the University of Minnesota Medical School.

Andrew E Cyrus, Jr, MD,* Sheboygan, director of laboratories at St Nicholas Hospital, recently announced that he will seek election as Sheboygan County coroner. He previously had served two terms.

M Thomas Edwards, MD and **Vinay D Luthra, MD,** Wausau, recently joined the medical staff of the Wausau Medical Center. Doctor Edwards graduated from the University of Iowa completing the joint PhD-MD program with a doctorate in physiology in 1976 and a doctor of medicine degree in 1977. He completed his residency training in pediatrics at the University of Iowa Hospitals. Doctor Luthra graduated from Lokmanya Tilak Municipal Medical College in Bombay, India, and served an internship and a radiology residency at the Lokmanya Tilak Municipal General Hospital, Bombay. He also completed a three-year residency in radiology at the University of Illinois Hospital in Chicago.

Marc Ringel, MD, Ripon, recently opened his medical practice at the Clara Zobel Baker Memorial Clinic at Ripon Memorial Hospital. Doctor Ringel graduated from the University of Illinois Medical School in 1974. He served his internship at Cook County Hospital, Chicago. Prior to coming to Ripon, Doctor Ringel worked as a staff physician for the National Health Service Corps in Yuma, Colo, and as a clinical instructor in the Department of Preventive Medicine at the University of Colorado School of Medicine.

James Kirchhoffer, MD, recently began his medical practice in Tomahawk. He graduated from Hahnemann Medical College, Philadelphia, in 1977, and completed his residency in internal medicine at Bridgeport Hospital, Bridgeport, Conn.

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Bayard Frederick MD, Park Falls, recently became associated with the Lakeland Medical Center. A specialist in internal medicine, Doctor Frederick completed his residency at St Joseph's Hospital and the Marshfield Clinic. He graduated from the University of Wisconsin Medical School, Madison.

Steve Novacheck, MD, Park Falls, recently became associated with the Lakeland Medical Center. A graduate from the University of Wisconsin Medical School, Madison, Doctor Novacheck completed his family practice residency at St Mary's Hospital and Medical Center, Madison.

Warren H Williamson, MD,* Racine, recently was featured in "We salute . . . ." of the *RACINE JOURNAL TIMES.* Doctor Williamson has served as president of the Racine Area Chamber of Commerce; helped found the A Center; served as chairman of the Central City Committee; served as president of Racine Family Planning Inc; director of the health division for the Southeastern Wisconsin Regional Planning Commission, member of the board of directors of the Racine County Area Foundation and consultant to the Wisconsin-Upper Michigan Synod of the Lutheran Church of America. Doctor Williams also has been president of the Racine County Medical Society and chief of the medical staff at St Luke's Hospital. He also is an alternate delegate to the AMA. As president of the Racine Area Chamber of Commerce, he was the only physician to hold that position in the Chamber's 68-year history.

Moe L Chin, MD, Watertown, recently became associated with Medical Associates of Watertown, SC, in the department of family practice. He graduated from the University of Washington Medical School and completed his residency at St Michael Hospital, Milwaukee, an affiliate of the Medical College of Wisconsin.

Maurice Greenberg, MD,* Dousman, and **Frank E Maddison, MD,*** Wauwatosa, have been selected for fellowship in the American College of Radiology. Doctors Greenberg and Maddison will receive their awards during the annual meeting of the ACR in New Orleans in September.

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SERVING SOUTHERN-CENTRAL WISCONSIN

John Monsted, MD,* (above), New London, recently retired from his medical practice after nearly 54 years. He will continue as the city health officer, a position he has held for 12 years and recently was elected to serve again. Coming from a family of physicians, Doctor Monsted graduated from Marquette University School of Medicine and completed his internship at Milwaukee County Hospital. In 1975 he was honored by the community for his 50 years of service and also became a member of the "50 Year Club" of the State Medical Society of Wisconsin. (Photo courtesy *New London Press—Star)*

Bruce C Herman, MD, Thiensville, recently opened his internal medicine practice at the Mequon-Thiensville Medical Center. Doctor Herman, director of the Center which is sponsored by Deaconess Hospital, Milwaukee, graduated from the Medical College of Wisconsin and completed his residency at Mount Sinai Medical Center in Milwaukee.

Rudolph C Hecht, MD* Madison, and wife, Ilse, RN, recently returned home after spending two weeks at the Marfa Medical Clinic in Texas. Doctor Hecht and his wife were involved with a program through the American Medical Association, Project USA, while Charles Thurston, MD, resident doctor, had been on vacation. "The project developed by the AMA is designed to provide relief for young doctors who are operating on an educational loan payback with the National Health Services," said Doctor Hecht. Doctor Hecht was actively in medical practice in Texas from 1957-1973 until he became a member of the faculty of the University of Wisconsin Medical School. He has received the Physician's Recognition Award of the AMA in 1970, 1973, 1976, and 1979. Doctor Hecht is the medical director for the Department of Family Medicine and Practice at the University of Wisconsin Medical School in Madison. ■

News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Froedtert Memorial Lutheran Hospital will have an open house and health fair the weekend of September 13-14 from 12:00 noon to 6:00 pm in celebration of its formal opening on September 29. Located in Wauwatosa on the campus of the Milwaukee Regional Medical Center, Froedtert Hospital will facilitate the expansion of the Medical College of Wisconsin's clinical research and educational capacities, according to a hospital spokesman. He further said that the sharing of sophisticated technology, research and educational facilities by Froedtert, the Milwaukee County Medical Complex, the Medical College of Wisconsin, Curative Rehabilitation Center, and other healthcare organizations located on the campus will result in major advances in the availability of tertiary-level healthcare in Wisconsin.

Of the 27 major medical services available through the two Medical Center hospitals, Froedtert's clinical programs include: dermatology, endocrine/metabolic, gastroenterology, general/multispecialty, neurology, neurosurgery, oral surgery, otolaryngology, plastic and reconstructive surgery, pulmonary medicine, renal, renal transplant, and urology. All of the other 14 major clinical programs and medical services will remain at the Milwaukee County Medical Complex.

All medical staff members have faculty appointments at the Medical College of Wisconsin. Russell K Lawson, MD, chairman and professor of urology, is the new hospital's chief-of-staff. Walter J Hogan, MD, professor of medicine, is vice chief-of-staff. Charles L Junkerman, MD* is Froedtert's vice president for academic and professional affairs.

Further details of the hospital's opening appear in an advertisement on page 43 of this issue. All State Medical Society members and their families are invited to attend.

Lake Winnebago Area Health Protection Plan (HPP), a health insurance program developed by the Wausau Insurance Companies in Wisconsin, is being offered to employers in seven counties. Timothy T Flaherty, MD,* Neenah, is heading a special committee formed to oversee the introduction and operation of the Plan. The HPP is being offered in Calumet, Green Lake, Marquette, Outagamie, Waupaca, Waushara, and Winnebago counties. Other physicians on the 10-member operating committee are: MDs James Basiliere,* Oshkosh, internist; Richard S Cline,* Appleton, obstetrician and gynecologist; John H Gray,* Neenah, surgeon; William B Grubb, Jr.* Appleton, radiologist; Francis P Larme,* New Holstein, general practitioner; Joseph W Weber,* New London, family physician Johan A Mathison,* Oshkosh, surgeon; William R Richards,* Appleton, orthopedic surgeon; and Michael Tieman,* Berlin, surgeon. The operating committee will review operations and recommend changes in the total Plan activities, including changes in the benefits structure.

St Joseph's Hospital, Chippewa Falls, recently announced the election of officers to its medical staff. Warren K Wright, MD,* pathologist, president; Reynaldo C Maniquiz, MD,* family physician, vice-president; and Mahmoud S Taman, MD,* psychiatrist, was elected secretary-treasurer. Doctor Wright, director of laboratory medicine and chairman of the department of pathology and continuing medical education committee, has been chief pathologist at the hospital since 1971.

Gundersen Clinic, Ltd, LaCrosse, is observing its Golden Anniversary this year. When the Clinic opened in 1930, its medical staff consisted of eight physicians. Today the Clinic's medical staff numbers 135 physicians and 625 paramedical personnel. The Clinic presently is considered one of the nation's ten largest multispecialty group practices.

United Health Services, Inc, Appleton, has announced the appointment of C William Freeby, MD,* vice-president of medical affairs. Doctor Freeby graduated from Indiana University School of Medicine and had been in private practice in Decatur, Ind. Prior to his new appointment he was vice-president and medical director of Aid Association for Lutherans with supervisory responsibility for underwriting and claim consultation, medical examiners and home office medical services. Doctor Freeby is certified by the American Board of Family Practice and the Board of Life Insurance Medicine. United Health Services, Inc, is the result of the unification of the medical and dental staffs of Appleton Memorial and St Elizabeth hospitals.

PhDs James and Elizabeth Miller, husband and wife team of scientists, both professors of oncology, McArdle Laboratory for Cancer Research, University of Wisconsin, Madison, are joint recipients of the 1980 Charles S Mott prize of the General Motors Cancer Research Foundation for their contributions to the knowledge about chemical carcinogens. Their studies laid the groundwork for the detection of cancer-causing chemicals in the environment, which are believed to be instrumental in the development of as much as 70 percent of all cancer. The award, including a gold medal and $100,000, was presented by Thomas A Murphy, chairman of General Motors Corporation, at

the Dean Acheson Auditorium of the State Department, June 18, in Washington, DC. That same day the laureates delivered lectures on their prize-winning projects at the National Academy of Sciences. The Millers, who are members of the National Academy of Sciences, have conducted extensive joint research with chemical and environmental carcinogenesis since the 1940s. Their work has brought them more than a dozen awards.

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CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U S A

Licensor of Merrell®

References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M T, O'Dillon [Dillon], R H, and Leyland, H M: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed. New York, Raven Press, 1978, pp 391-404

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9 4672 (Y957A)

Overweight may not always be simple... complications can develop*.

Complicated or not...

Tenuate® Dospan® ©IV

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

Alpha Stimulation

Central Control of Blood Pressure*

The Family of Man by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

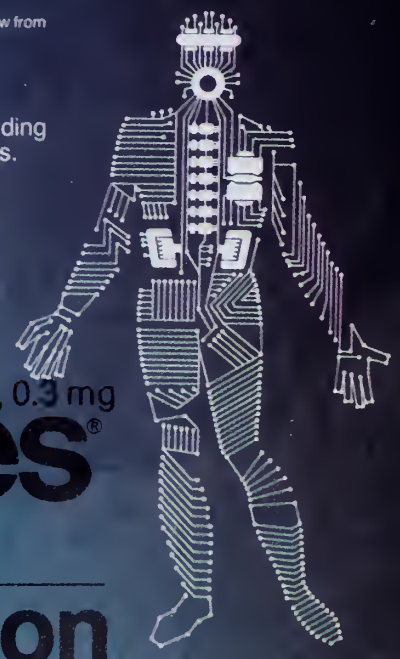
Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1 Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.



Now available in new 0.3 mg tablets

Tablets of 0.1, 0.2, 0.3 mg

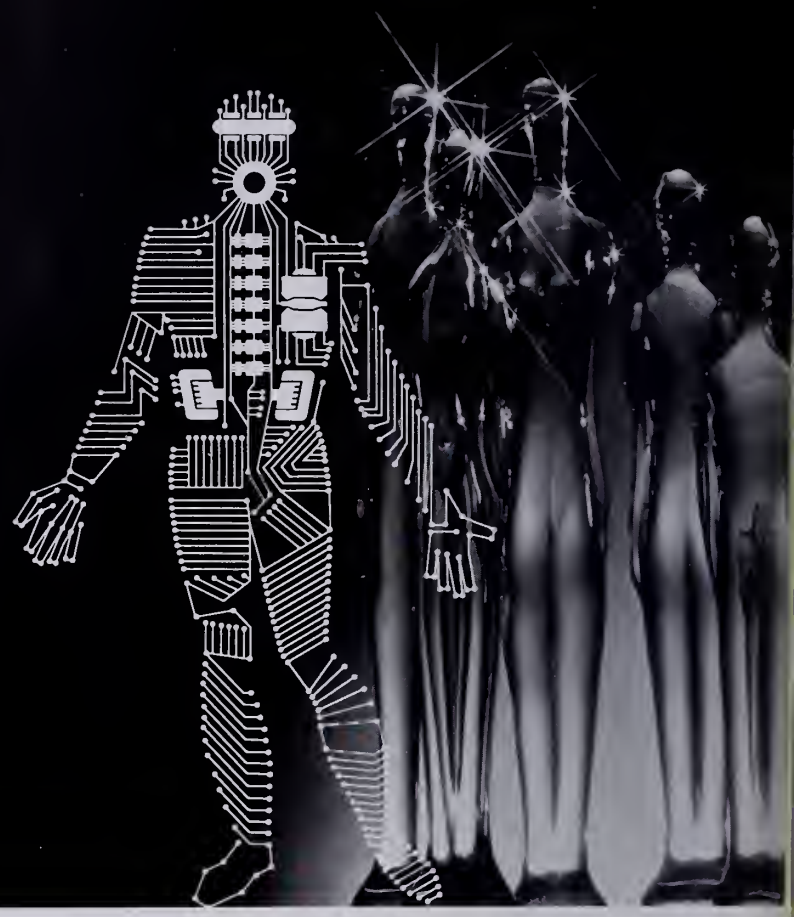
Catapres®

(clonidine HCl)

Hypertension

The Alpha Advantage:

It's for all kinds of hypertensives



Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at bi fast and 0.1 mg at bedtime. Some patients may be from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed

For optimal results, the dose of Catapres must be adjusted according to the patient's individual bloo pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 longer.

Adverse Reactions: The most common reactions are dry mouth, drow sedation. Constipation, dizziness, headache, and fatigue have beer Generally these effects tend to diminish with continued therapy. Th reactions have been associated with the drug, some of them rarely instances an exact causal relationship has not been established.) The Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abno liver function tests; one report of possible drug-induced hepatitis with and hyperbilirubinemia in a patient receiving clonidine hydrochlor thalidone and papaverine hydrochloride. Weight gain, transient elevati glucose, or serum creatine phosphokinase: congestive heart failure, phenomenon; vivid dreams or nightmares, insomnia, other behaviora nervousness, restlessness, anxiety and mental depression. Also gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not with a rash, impotence, urinary retention, increased sensitivity to alcoh itching or burning of the eyes, dryness of the nasal mucosa, pallor, gyn weakly positive Coombs' test, asymptomatic electrocardiographic ab manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, dimin sent reflexes and vomiting followed the accidental ingestion of Catapre hydrochloride) by several children from 19 months to 5 years of a lavage and administration of an analeptic and vasopressor led to c covery within 24 hours. Tolazoline in intravenous doses of 10 mg at intervals usually abolishes all effects of Catapres, (clonidine hydrochl dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.
For complete details, please see full prescribing information.
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Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

Anesthesiologist wanted to join the Central Wisconsin Anesthesiology, SC, which consists of three established, hospital-based anesthesiologists. All specialties are served including open heart, neuro, obstetrics & gynecology. If interested phone 715/845-5505 or write to: Central Wisconsin Anesthesiology, SC, 425 Pine Ridge Blvd, Suite 207, Wausau, Wis 54401. 7-9/80

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 20-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 7tfn/80

Internist wanted to practice in conjunction with a six-member Internal Medicine Department of a 20-physician multispecialty group, located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen L Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. Phone: 414/632-7521. 8tfn/80

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

Primary care physician needed for exquisite community near Lake Winnebago in east central Wisconsin. Close to large city with university and excellent recreational facilities. Join physician in practice near clinic with partnership opportunity after first year. Salaried position of 65K with lovely home and car provided. Excellent benefits. Call Durham Medical Search at 716/852-5911. 505-N Statler Office Building, Buffalo, NY 14202. 8/80

Physician-General Practice. $60,000/year- 60 hours/week. Practice in a modern medical clinic. Completion of AMA recognized internship, licensability, and highly acceptable references are required. Contact Steven H Spencer, Algoma Memorial Hospital, 1510 Fremont St, Algoma, WI 54201. p8/80

Seeking Full-Time Emergency Room physician. Southeastern Wisconsin. Contact John M Larsen, MD, Emergency Room Associates, Kenosha Memorial Hospital, Kenosha, Wis 53140. 7-8/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Family practice. Wanted a family practitioner to locate in new clinic building in Poynette, Wis. Located 30 miles from Madison, Wis. Poynette is a village of approximately 1000 with a service area of 7000 persons. Salary guaranteed. Contact John Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 8/80

General surgeon wanted to join 28-member multispecialty group in southern Wisconsin town of 50,000. Present surgeon in group retiring after 33 years of practice. Modern 256-bed hospital located next to new clinic building. Salary based on incentive. Call collect or write: Mayer Katz, MD, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, Wis 53511. 608/364-2230. 8/80

Family practice. Younger family physician for association in practice. Individualized practices, and coverage reciprocity. Contemporary modern office. New 165-bed family practice hospital under construction. Write to: Physicians in Family Practice, 120 Siegler St, Green Bay, Wis 54303. 414/497-0707. 8-9/80

GP or FP wanted to take over my practice while on leave for two years. Well-equipped, 2-man medical facility, near 55-bed hospital, 80-bed nursing home attached. Trade area 15,000. Good schools, churches, rural, good hunting and fishing nearby. Reply with CV to Dept 479 in care of the Journal. 7-9/80

General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

OBSTETRICIANS-GYNECOLOGISTS WANTED

Obstetricians-Gynecologists board certified or eligible wanted to join in practice with obstetrician-gynecologist in a city of 100,000 on Lake Michigan between Milwaukee and Chicago. Excellent schools, medical school affiliation, security of freedom of practice in independent small group. Contact: Elizabeth A Steffen, MD, 734 Lake Ave, Racine, Wis 53404. Phone: 414/637-8311. 6tfn/80

Physicians Exchange

continued

Multispecialty Group of 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Dermatologist
- Ophthalmologist
- Family Practitioner
- Psychiatrist

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. No personal investment. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

Internist wanted for half-time position: to work in the Geriatric Outpatient Clinic at Family Hospital in Milwaukee. The clinic is located in a newly remodeled 5000 sq ft facility and is part of the larger WRGC, an affiliate of Mount Sinai Medical Center. The physician will have his/her own panel of patients, have flexible hours, but no call responsibilities. He/she will work in a multidisciplinary team of social workers, geriatric nurse practitioners, and therapists. Send CV or call Robert W Timberlake, Administrator, Communications and Development, Family Hospital, 2711 West Wells, Milwaukee, Wis 53208. Tel: 414/344-9400, ext 225. 7-8/80

Wisconsin, Oshkosh: Career Emergency Physician with residency training and/or experience as emergency physician. Well-established fee-for-service corporation. Active community hospital with brand new physical facilities. Excellent staff backup, paramedic program, telemetry, flexible scheduling, competitive salary. Fringes: funded CME, generous health and disability insurance allowance, corporate-paid retirement plan, one month vacation, paid malpractice. ACLS certification required. Send complete CV: T M Loescher, MD, 2520 Crestview Dr, Appleton, Wis 54911. 7-9/80

Indiana—Fort Wayne: Emergency physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc, 4400 Broadway, Suite 306, Kansas City, Missouri 64111, 816/931-3040. 7-9/80

Family Practice, Hales Corners, Wis—to join 3 physicians in established practice. Board eligible/certified family physician or general practitioner, OB experience preferred. Guaranteed salary, paid professional liability insurance, opportunity for future partnership. Send your curriculum vitae to Whitnall Family Practice, 6080 South 108 Street, Hales Corners, Wis 53130 or call 414/425-5566 p7-9/80

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- Orthopedic surgery
- Psychiatry
- Ophthalmology
- Urology
- Neurology
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- Family Practice
- Hematology/Oncology

Perfect location for good family living, 45 minutes from Madison and 90 minutes from Milwaukee. For details contact Robert E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566. Phone collect: 608/328-7000. 6-8/80

Internist—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

General surgeon wanted to join group of six family practice physicians in a rural community of northwestern Wisconsin. For additional information contact F H Goetsch, MD, Spooner, Wis 54801. Phone: 715/635-2151. 8-10/80

Rheumatologist wanted to join four orthopedic surgeons in a very desirable north central Wisconsin community with a drawing population of 70,000. Active practice assured, shared "on call" provided, research grants available. New Clinic facility located within new 35 million dollar hospital complex. Outstanding personal benefit programs, generous guaranteed income. For further information contact: Lloyd Engstrom at 715/842-3202, or write PO Box 1646, Wausau, Wis 54401. 8-12/80

Board Certified or Eligible Pediatricians for full or part-time positions in teaching hospital and medical school affiliated community ambulatory care center. Appointees will work as members of existing primary care group of faculty pediatricians and internists. Positions immediately available, starting date flexible. Faculty appointment in the Department of Pediatricis, Medical College of Wisconsin. Competitive salary and fringe benefits. Wisconsin licensure required. Contact G A Limbeck, MD, Director, Department of Pediatrics, Milwaukee County Medical Complex, Box 148, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-6392 (collect). p6-8/80

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Family Practice
- Cardiology
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Wanted. Board Certified or Eligible OB/GYN; immediate opening with 8 physicians; multispecialty group of 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon. Clinic building is next to community hospital; expanding service area in western Milwaukee metro fringe location; first-year salary with optional second-year corporate stockholder; excellent fringe benefits including pension and profit-sharing plans. Contact J L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone 414/673-5745 collect. 5tfn/80

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Family Physician: Appleton, Wis, to join 4 certified ABFP physicians. City of 60,000 - economy based on stable paper industry. Excellent sports area. Near two fine hospitals and excellent consulting specialists. Contact: K E Buchanan, MD, 620 Longview Dr, Appleton, Wis 54911 or phone: 414/734-7144. 6-8/80

Board certified general surgeon desires to relocate in Wisconsin near large city. Wisconsin license. Willing to do some general practice. References upon request. Contact Dept 481 in care of the Journal. 7-11/80

Family Physician—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

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Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

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Phone: 608/263-4095

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Bookshelf

New books received *are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.*

Handbook on Poisoning. 10th Edition. By Robert H Dreisbach. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1980. Pp 577. Price: $9.00.

Fridericus. By Frederic F Flach. Lippincott & Crowell, Publishers, 521 Fifth Ave, New York, NY 10017. 1980. Pp 254. Price: $9.95.

Human Nutrition. Edited by Roslyn B Alfin-Slater and David Kritchevsky. Plenum Publishing Co, 227 W 16th St, New York, NY 10011. 1980. Pp 424. Price: $39.50.

Staging System for Cancer at Gynecologic Sites - 1979. American Joint Committee for Cancer Staging and End-Results, 55 East Erie St, Chicago, Ill 60611. 1980.

Reporting of Cancer Survival and End Results - 1979. American Joint Committee for Cancer Staging and End-Results, 55 East Erie St, Chicago, Ill 60611. 1980.

Manual for Staging of Cancer - 1978. American Joint Committee for Cancer Staging and End-Results, 55 East Erie St, Chicago, Ill 60611. 1980.

Basic First Aid. Second Edition. American Red Cross. 1979. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. Price: $5.25

Shocktrauma. By Jon Franklin and Alan Doelp. St Martin's Press, 175 Fifth Ave, New York, NY 10010. 1980. Pp 246. Price: $9.95.

NCHSR Research Management Series. Emergency Medical Services Systems Research Project Abstract, 1979. Prepared by Division of Extramural Research. U S Dept of Health and Human Services, 3700 East-West Highway, Hyattsville, MD 20782. 1979.

Superlearning. By Sheila Ostrander and Lynn Schroeder with Nancy Ostrander. Dell Publishing Co, Inc, 1 Dag Hammarskjold Plaza, 245 East 47th St, New York, NY 10017. 1980. Pp 357. Price: $4.95.

Handbook of Obstetrics & Gynecology. By Ralph C Benson. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1980. Pp 808. Price: $10.00.

Total Breathing. By Philip Smith. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1980. Pp 174. Price: $6.95.

Your Second Life: Vitality and Growth in Middle and Later Years. By Gay Gaer Luce. Dell Publishing Co, Inc, 1 Dag Hammarskjold Plaza, 245 East 47th St, New York, NY 10017. 1980. Pp 465. Price: $6.95.

Mega-Nutrition: The New Prescription for Maximum Health, Energy and Longevity. By Richard A Kun, MD. McGraw-Hill Book Co, 1221 Avenue of the Americas, New York, NY 10020. 1980. Pp 320. Price: $12.95.

Health and Prevention of Disease in a Free Society. By Albert L Fisher, MD. Published by LaCrosse Neuropsychiatric Clinic, 201-204 State Bank Bldg, LaCrosse, Wis 54601. 1980. Pp 337. Price: $12.50.

The Physician and Sportsmedicine Guide to Running. By Allan J Ryan, MD. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, New York 10020. 1980. Pp 103. Price: $7.95.

Cross-National Study of Health Systems: Concepts, Methods, and Data Sources. Gale Research Co, Book Tower, Detroit, Mich 48226. 1980. Pp 293. Price: $28.00.

Disorders of the Cervical Spine. By Eurig Jeffreys. Butterworths, 10 Tower Office Park, Woburn, MA 01801. 1980. Pp 147. Price $73.95.

Butterworth Medical Dictionary, 2nd Edition. Macdonald Critchley, Editor-in-Chief. Butterworths, 10 Tower Office Park, Woburn, MA 01801. 1980. Pp 1942. Price: $34.95.

Cesarean Childbirth. By Christine Coleman Wilson and Wendy Roe Hovey. Doubleday & Company, Inc., 245 Park Ave, New York, NY 10017. 1980. Pp 297. Price: $6.95.

Drink. Self-help Book on Alcoholism. By Constantine Fitzgibbon. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1979. Pp 200. Price: $8.95.

Adolescent Psychiatry—Vol VII. Edited by Sherman C Feinstein and Peter L Giovacchini. The University of Chicago Press, Chicago, Ill 60637. 1979. Pp 571. Price $21.25.

Active Loving. By Air Kiev, MD. Thomas Y Crowell Company, 10 E 53rd St, New York, NY 10022. 1979. Pp 149. Price: $8.95. ■

SEMINARS IN PEDIATRICS

October 9-11, 1980

Concourse Hotel and University of Wisconsin Clinical Science Center, Madison, Wisconsin

Presented by the University of Wisconsin-Madison, School of Medicine, Department of Pediatrics and University of Wisconsin-Extension, Department of Continuing Medical Education, Madison.

Seminar is open to Pediatricians, Family Practitioners, and General Practitioners and qualifies for 15 hours of Category I of the AMA-PRA and AAFP.

Fee: $200

Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Tel: 608/263-2856.

REGISTER NOW FOR THE 65th **Interstate Postgraduate Medical Association Scientific Assembly**

MGM Grand Hotel • Las Vegas, Nev.

November 3-6, 1980

Program planned under the direction of Alton Ochsner, MD, New Orleans, La, and in cooperation with the Nevada Academy of Family Physicians and the University of Nevada School of Medical Sciences

This prestigious annual educational conference offers . . . for only $125 . . .

- 24 hours prescribed credit, 4 elective hours AAFP
- 24 hours Category 1 credit, 4 hours credit in Category 5(a), PRA-AMA
- Program objective to update clinical knowledge in the diagnosis and treatment of the commonly occurring problems in cardiology, endocrinology, gastroenterology, prospective medicine, geriatrics, rheumatology, orthopedics, and nuclear medicine
- Special events and tours

For registration materials and program, return the form below to Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701

Name _____

Address _____

City _____

State _____ Zip _____

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of poblication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

WISCONSIN—1980

SEPTEMBER 11-13, 1980: *Wisconsin Society of Internal Medicine/American College of Physicians* combined Annual Meeting. Devil's Head Lodge, Merrimac. Approved 7 credit hours of Category I of the PRA-AMA. Info: Kim J Marggraf, WSIM Executive Office, 611 East Wells St, Milwaukee 53202.

SEPTEMBER 12-13: Wisconsin Surgical Society fall meeting, Lake Geneva.

SEPTEMBER 13-14, 1980: *Froedtert Memorial Lutheran Hospital Open House,* 9200 W Wisconsin Ave, Milwaukee 53226. See details on Page 43 of this issue.

SEPTEMBER 17, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

SEPTEMBER 24-27: *The Fifth Annual Nuclear Cardiology Symposium.* The Red Carpet Inn, Milwaukee. Sponsored by the University of Wisconsin-Extension, Department of Continuing Medical Education, Cardiovascular Disease Program, Milwaukee Clinical Campus, University of Wisconsin-Madison, School of Medicine, American Heart Association—Wisconsin Affiliate, and Society of Nuclear Medicine. Fee: Mini Symposium (Sept 24), $40/physicians; $18/technologists. Conference fee (Sept 25-27), $220/physicians; $85/technologists; $250/1 physician/1 technologist team. 16 credit hours AMA Category I. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

OCTOBER 3-5: Midwest Allergy Forum, sponsored by Wisconsin Allergy Society. Hyatt Regency Hotel, Milwaukee. Info: Morton Soifer, MD, 707 W Glencoe Pl, Bayside, Wis 53217.

OCTOBER 6-10, 1980 (first week), OCTOBER 13-17, 1980 (optional second week): *Cardiac Rehabilitation Workshop* offered through the joint effort of the LaCrosse Exercise Program and LaCrosse Lutheran Hospital/Gundersen Clinic, Ltd. Will provide indepth understanding and experience of all aspects of cardiac rehabilitation and a thorough understanding of the organizational and administrative aspects of a cardiac rehabilitation program. First week will consist of didactic lecture with structured laboratory experiences and examinations while the "optional" second week will allow the individual the opportunity to become involved as a "staff participant" in selected aspects of the LaCrosse Cardiac Rehabilitation Program. Accreditation through a number of agencies is offered. Further info: Workshop Unit—LaCrosse Exercise Program, Mitchell Hall, University of Wisconsin-LaCrosse, LaCrosse, Wis 54601 (608/785-8686).

OCTOBER 15, 1980: *One-Day Seminar for Family Physicians,* St Vincent Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

CLINICAL UPDATE IN PEDIATRIC NEUROLOGY

Hyatt Regency, Milwaukee, Wis

September 29-30, 1980

Sponsored by The Medical College of Wisconsin

TOPICS: Neurologic Emergencies; Learning and Behavioral Disorders; Neonatal Neurology, and Common Office Problems in Neurology.

GUEST FACULTY: *Arthur Benton, PhD,* University of Iowa, Iowa City, Ia; *Raymond W M Chun, MD,* University of Wisconsin Medical School, Madison; *Bernard J D'Souza, MD,* Johns Hopkins University School of Medicine, Baltimore, Md; *Kurt E Hecox, MD,* University of Wisconsin Medical School, Madison; and *James E Schwartz, MD,* Emory University School of Medicine, Atlanta, Ga.

Approved for 19 credit hours of Category I of the PRA-AMA.

INFO: Ms Jennie M Evenson, Dept of Neurology, The Medical College of Wisconsin, Milwaukee Children's Hospital, PO Box 1997, Milwaukee, Wis 53201. Tel: 414/931-4074.

OCTOBER 15-17: *The Sociopath 1980: A Practical Inquiry,* symposium and workshop addressing the problems of the community, the cop, the court, the classroom, and the clinician. Sponsored by the University of Wisconsin and the Mendota Mental Health Institute. Info: Bernadine Eve Bednarz, MSW (phone 608/263-4431) or write UW-Extension, 414 Lowell Hall, 610 Langdon St, Madison, Wis 53706.

OCTOBER 17-18, 1980: *Wisconsin ACEP/EDNA Fall Symposium,* Hyatt Regency, Milwaukee. ACEP member fee $125, nonmembers $150. Approved 12 credit hours of Category I of the PRA-AMA. Info: G L Gerschke, MD, 2025 E Newport Ave, Milwaukee 53211 or 414/961-3507.

OCTOBER 24-25: *Orthopedics for the Practicing Physician.* Wisconsin Center, and University of Wisconsin Clinical Science Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education, and University of Wisconsin-Madison, School of Medicine, Department of Orthopedic Surgery. Fee: $125. AMA Category 1 credit hours applied for. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 5-7: *Aging and Illness in Primary Care—Basic and Clinical Science Foundations.* Wisconsin Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and University of Wisconsin-Madison, School of Medicine, Departments of Medicine and Family Medicine and Practice. Fee: $215. 21 credit hours Category I of AMA; AAFP credit. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 7: Wisconsin Orthopedic Society meeting, starting at 9:00 am, Olympia Princess, Scottsdale Resort, Oconomowoc.

NOVEMBER 6-8: *2nd Annual Respiratory Critical Care Symposium: Acute Respiratory Failure—Admissions to Discharge.* The Inn on the Park, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and the University of Wisconsin Center for Health Sciences. Fee: $150/physician; $100/nurse, resident, allied health professional. 15 credit hours of Category I of AMA and Family Physician credit applied for. 1.5 CEU units. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 12, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

ILLINOIS—1980

SEPTEMBER 5-6: Illinois Congress on Continuing Medical Education, at Oak Brook Hyatt House, Oak Brook, Illinois. Theme: *Does CME improve physician performance?* This particularly urgent question is being addressed because the effectiveness of traditional CME is increasingly being questioned. In response to interest expressed by people from other states, CME planners from outside Illinois are being invited to this year's Illinois Congress. The theme of the Congress will be addressed directly by the speakers at two plenary sessions—Ronald W Richards, PhD, Director and Professor, Center for Educational Development, University of Illinois College of Medicine; and Richard M Caplan, MD, Associate Dean/CME at the University of Iowa. For additional information write or call the Illinois Council on CME at 55 East Monroe, Suite 3510, Chicago, Illinois 60603; (312) 236-6110. The Illinois Council on Continuing Medical Education was established in 1972 jointly by the Illinois State Medical Society and the state's eight medical schools and is supported primarily by contributions from ISMS members.

NOVEMBER 2-7: Annual Meeting, American Academy of Ophthalmology, McCormick Place, Chicago, Illinois. (Relocated from New Orleans to accommodate increasing attendance.) Info: AAO, 1833 Fillmore St, PO Box 7424, San Francisco, CA 94120, or call 415/921-4700.

DECEMBER 10-12, 1980: *Neurology for the Non-Neurologist,* Sheraton Plaza Hotel, Chicago, Ill. Sponsored by Rush-Presbyterian-St Luke's Medical Center. Approved 20 credit hours of Category I of PRA-AMA. Info: Leslie Bryan, CME, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina St, Chicago, Ill 60612. 312/942-7095. 8,10,12/80

ILLINOIS—1981

MARCH 2-6, 1981: Seventieth Annual Meeting of the United States-Canadian Division of the International Academy of Pathology, at the Palmer House, Chicago, Illinois. The Maude Abbott Lecture entitled "The Impact on Time on the Diagnosis and Treatment of Cancer: 1936-1981," will be delivered by Dr Lauren V Ackerman on March 3. Scientific papers, poster sessions, twelve specialty conferences, and 50 short courses are scheduled. A special course will be offered on "Immunopathologic Techniques in Diagnostic Pathology," with Dr Robert T McCluskey as course director. The long course will be on "The Inflammatory Process and Infectious Disease," with Doctors Guido Majno and Ramzi Cotran, course directors. Further info: Dr Nathan Kaufman, Secretary-Treasurer, United States-Canadian Division of the IAP, 1003 Chafee Avenue, Augusta, Ga 30904; telephone: 404/724-2973. g7-12/80

OTHERS—1980

SEPTEMBER 12-13, 1980: Introductory seminar for physician negotiators—*Dynamics of Conflict Resolution with Health Planning and Other Government Agencies,* at the Radisson-Muehlebach Hotel, Kansas City, Mo. Presented by the AMA Department of Negotiations. An organization accredited for continuing medical education, the AMA Council on Continuing Physician Education certifies that the continuing medical education activities designated Category I meet the criteria for Category I on an hour-for-hour basis for the Physician's Recognition Award of the AMA. For more information on above educational program, contact: AMA Dept of Negotiations, 535 North Dearborn St, Chicago, Ill 60610; or call 312/751-6652.

SEPTEMBER 15-18: *American College of Emergency Physicians.* Las Vegas, Nev. Contact: Communications Group, ACEP, 3900 Capital City Blvd, Lansing, Mich 48906.

SEPTEMBER 29-30: *National Conference on Patient's Rights,* sponsored by the American Society of Law & Medicine, at the Opryland Hotel in Nashville, Tennessee. Open to physicians, nurses, hosptial administrators, patient advocates, attorneys, social workers, philosophers, ethicists, chaplains, risk manager, and others interested in the growing movement to recognize and implement the rights of healthcare consumers. The 1970s saw the birth of the patient rights movement as an outgrowth of the civil rights movement and the malpractice crisis. This conference addresses the concept and context that patient rights will take in the 1980s, as the rights won in the 1970s are implemented.

Registration fee: $125 for members of the ASLM and $145 for nonmembers; includes a volume of conference materials and luncheons on both days. Advance registration required. To register, send name, address, and registration fee to: Conference Registrar, ASLM, 520 Commonwealth Ave, Boston, Mass 02215. g7-8/80

OCTOBER 9: *Hypertension in Family Practice: Evolving Concepts.* The Rivergate Exhibition Center, No 4 Canal St, New Orleans, LA. This symposium has been accepted as a special presentation immediately following the Annual Meeting of the American Academy of Family Physicians. Info: World Health Information Services, Inc, 475 Fifth Ave, Suite 505, New York, NY 10017. Phone: 212/679-6200. p7-8/80

OCTOBER 9-11, 1980: National conference to explore the role of medical determinations in workers' compensation proceedings, in Washington, DC. Conference concerned primarily with three areas of workers' compensation: (1) the application of current medical knowledge to causality assessment and disability evaluation in heart disease, cancer traumatic neurosis, and lung disease; (2) the usefulness of medically developed standards in workers' compensation rulings; and (3) the presentation of medical evidence in workers' compensation cases. Conference is intended for attorneys engaged in workers' compensation litigation, physicians who examine, evaluate and treat patients seeking compensation, insurers who evaluate such claims, and administrative agency personnel who adjudicate compensation proceedings. Faculty: Jack B Abramson, Esq of Reisman, Milberg, Abramson & Magro, PC, New York, NY; and John T Coyne, Esq of Carr, Jordan, Coyne & Savitts, Washington, DC. Sponsor: American Society of Law and Medicine, 520 Commonwealth Ave, Suite 211, Boston, Mass 02215; or call 617/262-4990.

OCTOBER 9-11, 1980: *American Cancer Society National Conference. Gynecologic Cancer*—1980. Los Angeles Hilton, Los Angeles, Calif. Approved 16 hours prescribed credit AAFP and Category 1 of the AMA-PRA. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference—Gynecologic Cancer—1980, 777 Third Ave, New York, NY 10017. g8-9/80

OCTOBER 17-18, 1980: Third National Invitational Conference for Physician Negotiators, at the Hilton Hotel, Las Vegas, Nevada. Designed for those involved with negotiations activities, for medical society leaders and executives, and for physicians who have attended one of the AMA seminars and desire to keep informed on negotiations. Contact: AMA Dept of Negotiations, 535 North Dearborn St, Chicago, Ill 60610; or call 312/751-6652.

OCTOBER 19-24: *Annual Clinical Congress, American College of Surgeons,* Atlanta, Georgia. Info: ACS, 55 East Erie St, Chicago, Ill 60611; (312) 644-4050, ext 324.

OCTOBER 19-24: *American Academy of Physical Medicine and Rehabilitation,* Washington, DC. Contact: Barry Miller, PO Box 995, Ann Arbor, Mich 48106, 313/572-3562.

OCTOBER 24-26: *American Academy of Neurological and Orthopaedic Surgeons.* Contact: Michael R Rask, Program Chairman, 2320 Rancho Drive, Suite 108, Las Vegas, Nev 89102.

OCTOBER 26-30: Annual Scientific Assembly of the American College of Chest Physicians, at the Sheraton Boston Hotel and Hynes Auditorium Convention Center, Boston, Mass. *CAT Scanning—Cardiopulmonary Disease* and *Detection, Diagnosis, and Management of Lung Cancer* are two of the six subjects to be discussed in the major symposia sessions. Full-day programs discussing such topics as occupational lung disease, critical care, perfusion technology, respiratory care, and echocardiography will be presented. Over 30 hours of credit may be obtained toward Category I of the PRA-AMA. Further info: Dale E Braddy, Director of Education, ACCP, 911 Busse Highway, Park Ridge, Ill 60068.

NOVEMBER 3-6: 65th Annual Scientific Assembly of Interstate Postgraduate Medical Association at the MGM Grand Hotel, Las Vegas, Nev. Info: Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701. g7-9/80

DECEMBER 6-11: American Academy of Dermatology, New York, NY. Info: AAD, Inc, 820 Davis St, Evanston, Ill 60201 (Phone 312/869-3954).

AMA—1980

DECEMBER 7-10: Interim AMA House of Delegates, San Francisco Hilton, San Francisco, Calif.

AMA—1981

FEBRUARY 12-15: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9: Interim AMA House of Delegates, Las Vegas Hilton, Las Vegas, Nev.

AMA—1982

FEBRUARY 25-28: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8: Interim AMA House of Delegates, Fountainbleu Hilton, Miami, Fla.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Toll free number 1-800/362-9080.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

INCORPORATION OF COUNTY OR SPECIALTY SOCIETY. Some county and specialty societies have asked the State Medical Society's advice on whether they are or should be incorporated, in what category they should seek tax-exemption, and the mechanics of doing either or both of these. It is suggested that each case should be evaluated on its merits. Any society wishing further information should contact the SMS's assistant secretary, Bernie Maroney, who also is the Society's corporate legal counsel, at SMS offices in Madison.

PATIENTS COMPENSATION FUND COLLECTS 1980 FEE ASSESSMENTS. The Patients Compensation Fund currently is in the process of collecting 1980 fee assessments. Fund fee assessments have been increased by 100 percent over the 1979 level. In evaluating the need for such a dramatic increase, it is important to note the experience of the Fund. During the first three years of the Fund's existence (1975-1977), no losses were paid. In 1978, $550,000 was paid. In 1979, $2.4 million was paid and indications are that the Fund will pay $5.0 million in 1980. The statutory provision (repealed during the past legislative session), which limited Fund fees to 10 percent of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) rate, prevented Fund fees from keeping pace with the increasing number and value of claims filed against the Fund and, in effect, the 100 percent increase is being used to make up lost ground.

Despite the unfavorable experience of the Fund in recent years, WHCLIP has had a better-than-expected experience and has granted a 15 percent reduction (effective July 1, 1980) in physician rates. This 15 percent reduction more than offsets the Fund increase and all physicians insured by WHCLIP will realize some savings this year. For example, an internist will save $40 over last year's total payment and an orthopedic surgeon will save $400 overall.

These changes, which when viewed together represent an overall rate decrease, come at the same time that actuaries nationwide are predicting troubled times ahead in the malpractice area. In fact, the New York physician-owned malpractice insurance company (New York Medical Liability Mutual Insurance Company), citing increased frequency and amount of claims, is raising physician rates from 17 percent (for some surgical specialties) to 36 percent (for family and general practitioners).

PHYSICIANS MAY ENROLL AS SCREENERS IN WISCONSIN EPSDT PROGRAM. The State Division of Health has announced that physicians now may enroll for the first time as screeners in the Wisconsin Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT, financed by state and federal sources through the state's Medical Assistance Program (Medicaid/T-19), is administered by the Division of Health. EPSDT is a preventive health system for children and young adults under age 21 years who are certified for Medical Assistance. Medical Assistance offers physicians greater reimbursement for preventive health programs such as EPSDT than for regular Medical Assistance visits. Screeners may receive additional compensation for immunization and laboratory work. Medical Assistance pays for diagnosis and treatment services separately. For more information on EPSDT or a detailed description of the screening standards and the periodicity schedule (both of which have been developed by the Physician Technical Advisory Committee), call 608/266-7164 or write the Division of Health, Bureau of Health Care Financing, EPSDT Section, PO Box 309, Madison, Wisconsin 53701. (See also the SMS Council's action in this issue under ORGANIZATION, page 39.)

OTHER *News You Can Use* ITEMS APPEAR ELSEWHERE IN THIS ISSUE. ■

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WISCONSIN MEDICAL JOURNAL

SEPTEMBER 1980

• HMOs—A divisive force in medicine? • The quiet holocaust • Echocardiography—1980 • Twins—still a perinatal problem • Interferon studies at the Wisconsin Clinical Cancer Center • Membership classifications for young physicians and for reduced practice • SMS Leadership Conference set for November 14 • Medicaid update

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*Present as 345.9 mg. and 691.8 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. and 600 mg. fenoprofen respectively.

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half-life

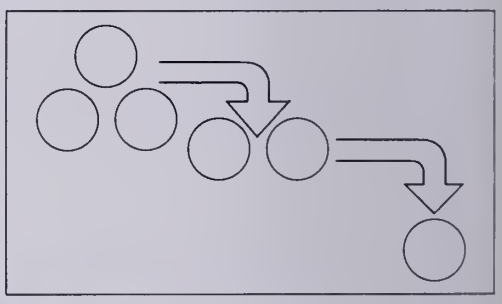
Just one built-in advantage

Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium* (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev 8*(1):5-11, 1978



in the management of symptoms of anxiety

Valium® (IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

Before prescribing, please see summary of product information on next page

ROCHE®

Valium®(IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

THE STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841 . . . Representing nearly 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections, with all members belonging to the American Medical Association. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's Page

Russell F Lewis, MD

HMOs—A divisive force in medicine?

AT THE recent AMA convention a very lengthy and scholarly report concerning Health Maintenance Organizations (HMOs) was adopted by the House of Delegates. There was no major policy change, and the House deferred action on the statement that HMOs seemed to help control costs. The few added recommendations had to do basically with physicians informing themselves about the HMO concept. It is important that all physicians in this state find out as much as they can about the HMO, factually, not anecdotally before they draw conclusions or decide to participate.

My definition of an HMO is that it is a medical delivery system involving physicians in the basic contract for delivery, quality, and cost of medical care.

Under fee-for-service the patient makes a contract with a physician to the effect that the physician will take care of the patient to the best of his or her ability. In return the patient agrees to pay the charges for receiving this service. At the same time, the patient may have an insurance company policy which is a contract for the insurance company to pay an agreed upon amount for certain services. This, however, is a contract between the patient and the insurance company. This may be a very comprehensive plan which also may be expensive. It also may be a relatively small area of coverage and not very expensive. There are, of course, all gradations between. Whatever is not covered by the insurance company is expected by the providers to be paid by the patient.

In the HMO concept the physician becomes a party to that contract. Almost always the benefits are extremely comprehensive, but the physician agrees to provide those services for a predetermined reimbursement. Depending upon the situation the physician may or may not break even. Obviously if the physician makes much, the patient will not accept this over a long term; and if the physician loses, the physician cannot afford to continue.

From the patient's standpoint it is a good arrangement. They are assured of accessibility of care. If the coverage is comprehensive, the patient knows what it is going to cost almost to the dollar. Patients are rarely at risk for unforeseen expenses in contrast to the usual indemnity program which often requires coinsurance, deductibles, and patients paying for services not otherwise covered in the contract.

The insurance company gains because now the physician becomes a partner. Most insurance people with whom I have talked through the years have been afraid to cover outpatient and office medical services for fear that a few irresponsible physicians having high financial incentives would take advantage of that type of program. Therefore, most indemnity insurance programs cover primarily hospital care. Under the HMO the physicians must participate in assuming responsibility for policing the delivery of care by all the participating providers. This means cost control and especially utilization control of physicians, a fact very much appreciated by the insurance company.

For the physicians the major change is that now they are at risk financially, and they are involved in a business for which they are not trained, namely insurance. The basic question physicians have to ask themselves is: are the advantages involved in the HMO-type of program worth more than the disadvantages?

Just a few words concerning the cost of care. Almost all the reduction, if there is such in cost of care, has to do with the fact that most ambulatory service is covered and so hospital costs are reduced. There are other savings potentially in that the money comes in immediately, there are no bad debts, and no collection problems for the provider.

While this whole concept is not new, what is new is the emphasis being placed on this alternate delivery service system by a multitude of organizations.

I. Consumers. There are increasing numbers of consumers getting together and asking for this type of delivery service. In most cases this is easily federally financed and the basic HMO contracts with physicians to provide the services. Many physicians are interested in this type of arrangement, in some cases because the consumers are intensely interested about their own healthcare.

II. Group Practice. More and more large medical groups are becoming interested in this concept from the standpoint of public relations, for maintaining referrals, for enlarging their area, etc.

III. Industry. We now have several examples in Wisconsin of large manufacturing companies that have insisted in establishing HMOs to try to control the cost of care. This has been done in local areas basically through the county medical society and an insurance company.

IV. Labor. This arrangement is a natural for labor. It is an easy position from which to negotiate, provides good coverage to the union members; and now labor in cooperation with industry is expanding its role in HMO development.

V. Hospitals. Basically the HMO concept is an unhappy one for hospitals. The major emphasis is on reducing hospital costs by reducing hospital utilization. However, in competitive situations with overbedding now existing in many areas, a number of hospitals are beginning again to look seriously at establishing HMOs in order to maintain their patient base.

VI. Physicians. Because HMO development inevitably results in loss of patients, other area solo and group practitioners have to look at an alternative. The Foundation, now called Independent Practice Association (IPA) seems to be a logical one. Even groups of physicians as large as the Health Systems Agency (HSA) districts in Wisconsin have become involved. It should be pointed out that in many communities there has been favorable public relations with patients through this movement.

VII. Insurance companies. In recent years insurance companies have had to look very closely at this approach because as HMOs increase the companies are losing some of their regular business. In addition, a number of insurance companies, not particularly active in this field before, see this as an area in which there is money and that means money is to be made. All over the United States large and successful insurance companies have become very active and have established HMOs independently or in conjunction with groups of physicians or consumers. This is their area of expertise. It also is my area of concern.

In Marshfield there has been an HMO for almost ten years. This was begun in conjunction with Blue Cross, and it has been a good partnership. The HMO business is now becoming extremely competitive. As a result if one looks at the cost of care, it becomes apparent that hospital utilization under an HMO program within one or two years reaches a reasonable minimum; and there will be very little cost savings thereafter. One concept of an HMO is to make care accessible and this mitigates against markedly reducing utilization by patients. The obvious place in which to save money, therefore, is the physician's office. This can be attacked either through fees or utilization, particularly of laboratory and x-ray procedures. It is inconceivable to me that the insurance companies will not put pressure on physicians in these areas and I think this is being demonstrated in Wisconsin. Such pressure can affect quality. Government is very active in HMOs, both with promotion and outright subsidy. Its interest is especially with cost control. My concern comes back to the original statement, physicians should look before they leap. As a physician involved in an HMO, I think it is great for some doctors and some locations but not all. I am firmly convinced that each community is different. In many situations there will be patients willing to give up free choice of physician in return for the other benefits of the HMO. The insurance companies have little to lose and much to gain, but the bottom line comes down to the fact that physicians are being put at financial risk in many instances without much to gain in return.

One other concern has to do with the fact that as HMOs become more competitive, most marginal or high-risk people will be excluded and concentration will be on the healthy group. This only gives impetus to a growing group of people who cannot get into HMOs, and they will press for the alternative of National Health Insurance (NHI).

Physicians should control their own destiny as long as possible. As they enter into HMO arrangements, they should have a clear understanding of their role in the management.

The State Medical Society Council has considered the development of HMOs. The Society's policy is to encourage multiple forms of delivery and to act as a resource for physicians or others interested in contracting with or establishing an HMO. Whether the Society can or should have any other role is certain to get the Council's attention in the future. ■

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Two important steps

IN A PAIR of reports, a year in the making, the State Medical Society has moved the State of Wisconsin two important steps forward in its planning for physician distribution and public health.

"Physician Distribution in Wisconsin" is a thorough analysis of a much bandied about subject. Its facts are crisp: There is no overall shortage . . . there are shortage areas. No shortage is foreseen for at least a decade. The shortage areas are identified. There are about 35, mostly small in area, mostly rural. The report suggests 10 remedial actions, most requiring cooperative action of physicians, state, and local communities.

"The Public Health System in Wisconsin" is an eye-opener. It calls for a major rearrangement of the power blocks of public health policy at the state and local level. For half a century the State Medical Society has been calling, somewhat forlornly, for a city-county-multiple county health structure. Rarely has the call been heeded. That call is made again. This time it is coupled with reorganization, consolidation, and hopefully revitalization of state and local public health programs. Perhaps most importantly the report calls for a prominent practicing physician role in preventive and health maintaining activities, plus a much more well-defined and realistic transfer of "delivery" functions to practicing physicians where most people prefer to get their care in the first place.

Every physician should read these reports. Anyone interested in Wisconsin's better health would be well advised to do the same. Whether two important steps can become a long, healthy walk will be decided by public and legislative acceptance of the Society's proposals. The Society should make it a priority pursuit.

Sick in a strange land

PERHAPS YOU have experienced severe illness when traveling in a foreign country. It is a feeling of helplessness and fright.

Think then of the feelings of some 6000 Indo-Chinese who have recently come to live in a land strange to them—Wisconsin. Think of their helplessness and fright when they, a child or relative becomes sick, as they surely will. Those who can help can't speak the language. Physicians are often unfamiliar with the diseases these refugees have brought along. And the Indo-Chinese don't know how to use the medical system.

The State Medical Society is working with public health units to coordinate the location of translators with those who need the care. Physicians can help by making known their willingness to serve the Indo-Chinese refugees. If you will accept such persons as patients, please write: SMS-Indo-Chinese Care, PO Box 1109, Madison, Wisconsin 53701. Your response can bring new hope to those who are sick in a strange land—ours.

So young, so aspiring!

IN THIS ISSUE is a paper by Karen Middleton who was a 17-year-old senior high school student at James Madison Memorial High School in Madison, Wisconsin at the time it was written. Karen has a list of accomplishments long enough to awe even the most industrious. She already is considered a veteran of laboratory work and science congresses. She has done projects in the National Science Foundation program at the University of Iowa and the Ochsner Clinic in New Orleans, and in her senior year she was one of 40 national winners in the Westinghouse Science Talent Search. In July 1979 the American Medical Association presented Karen, then age 16, with a Special Achievement Award in recognition of the AMA's admiration for her superlative accomplishments, particularly in medical research. In June of this year she made a brief presentation to the Society of Nuclear Medicine and then worked this summer at the National Institute of Allergy and Infectious Disease in Bethesda, Maryland. This fall she entered the University of Michigan's accelerated medical program which will enable her to earn an MD degree after six years of study. As indicated in this paper, Karen is interested in tropical diseases and hopes to work in southeast Asia or Africa. We wish her well!—VSF ■

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ectiveness of Equagesic in long-term use, i e an four months, has not been assessed by atic clinical studies. The physician should pe- ly reassess usefulness of the drug for the indi- patient

NDICATIONS: Equagesic should not be given to with a history of sensitivity or severe intolerance meprobamate, or ethoheptazine citrate

S: Careful supervision of dose and amounts pre- patients is advised, especially with those patients propensity for taking excessive quantities of drugs and prolonged use in susceptible persons, e g , former addicts, and other severe psychoneurot- reported to result in dependence on or habit- e drug Where excessive dosage has continued or months, dosage should be reduced gradually n abruptly stopped, since withdrawal of a "crutch" ptate withdrawal reaction of greater proportions or which the drug was originally prescribed Abrupt ance of doses in excess of the recommended dose ed in some cases in the occurrence of epileptiform

re should be taken to warn patients taking mepro- at tolerance to alcohol may be lowered with re- wing of reaction time and impairment of judgement nation

N PREGNANCY AND LACTATION: An in- sk of congenital malformations associated with f minor tranquilizers (meprobamate, chlordi- azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but as a rule this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

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WHY NOT WYGESIC® ©

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommendad Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependance and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphanadrine

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supp tive measures should be used as indicated Gas lavage may be helpful Activated charcoal can sorb a significant amount of ingested propoxyphe Dialysis is of little value in poisoning by propo phene alone. Acetaminophen is rapidly absort and efforts to remove the drug from the body sho not be delayed. Copious gastric lavage and or ind tion of emesis may be indicated Activated char is probably ineffective unless administered sim immediately after acetaminophen ingestion Ne forced diuresis nor hemodialysis appears to be fective in removing acetaminophen Since acet nophen in overdose may have an antidiuretic ef and may produce renal damage, administratio fluids should be carefully monitored to avoid o load It has been reported that mercaptamine (teamine) or other thiol compounds may protect against liver damage if given soon after overdosage (within hours) N-acetylcysteine is under investigation as less toxic alternative to mercaptamine, which ceuse anorexia, nausea, vomiting, and drowsin Appropriate literature should be consulted for fur information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity be delayed up to one week Acetaminophen pla levels and half-life may be useful in assessing likelihood of hepatotoxicity Serial hepatic enz determinations are also recommended

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Special

The quiet holocaust

Karen Middleton, Madison, Wisconsin

KAREN MIDDLETON

THE AMERICAN PEOPLE are reacting with shock, horror, and compassion to the spectacle of mass starvation and death in Cambodia. But there is a far greater human disaster that happens quietly and regularly every year, largely outside the notice of the American public.

Last year some 25 million children under the age of five died. About 97 percent of these children lived in the less developed countries (LDCs). In many areas one-fourth or more of the children regularly die before their fifth birthday. Unless the people in the United States and other developed countries work to bring fundamental changes, another 25 million will die this year, and the next, and the next.

There can be no lasting peace and justice in the world as long as the major part of the world's population lives in extreme poverty, afflicted with devastating diseases. The United States, as the wealthiest nation in the world, bears a special responsibility to help the poorer countries overcome their problems of hunger and disease.

The statistics on health conditions in most of the world's countries are grim:

—In LDCs the infant mortality rate is eight times higher than in the United States.

—Five million children die each year from diphtheria, pertussis, tetanus, poliomyelitis, measles, and tuberculosis. Measles is the major killer of children in countries such as Zambia and Tanzania. Most of these deaths could be prevented with immunizations and modern treatments.

—About 100 million children suffer from moderate or severe malnutrition, and malnutrition plays a major role in the deaths of more than half of all children. Among malnourished children measles, diphtheria, and polio can kill as many as 10 percent and tetanus up to 70 percent of those afflicted. Those who are not carried off by disease may suffer brain damage and stunted growth.

—Vitamin A deficiency causes 20-100,000 children to lose their sight each year. In some parts of Africa one person in ten is blind as a result of filarial worms causing "river blindness" (onchocerciasis).

—In LDCs 71 percent of the people do not have access to safe drinking water, and diarrheal and other water related diseases kill millions each year.

—In LDCs 77 percent of the doctors live in urban areas, but 77 percent of the population live in rural areas, where there is only one doctor for every 47,000 people. Most have no access to effective medical care.

—More people suffer and die from tropical diseases than from all other serious diseases combined. Some 300 million have malaria, and in Africa alone it causes the death of 1 million children each year. About 300 million are afflicted with filariasis, 200 million with schistosomiasis, 35 million with African trypanosomiasis, and 11 million with leprosy.

While the United States and other developed countries have developed a sophisticated, high-technology medicine, the major diseases of the world have been sadly neglected. This year the National Institutes of Health will spend almost $3 billion for medical research, including $797 million for cancer research. Yet worldwide only $60 million will be spent on research on tropical diseases, which are by far the major causes of death in the world. The entire budget of the World Health Organization is only double that of the University of Wisconsin hospital and medical school in my home town. The WHO/World Bank/UNDP Special Programme for Research and Training in Tropical Diseases receives only about $20 million a year—less than the cost of

A list of 41 references accompanying this paper is available upon request to the author: Karen Middleton, 6402 Landfall Drive, Madison, Wis 53705 (phone: 608/233-1575). Copyright 1980 by the State Medical Society of Wisconsin.

one F-14 Tomcat jet fighter or two helicopters.

The United States should do far more. US foreign aid as a percentage of gross national product fell from 0.49 to 0.26 between 1965 and 1975 and is today far below the level provided by most other OECD nations. Futhermore, only 3 percent of all US foreign aid is devoted to health services. This is very short-sighted, since improving the health of an impoverished people is one of the most effective means of stimulating economic development.

What steps should the United States take? I would suggest these:

(1) Develop a coordinated US policy and program in the area of international health. Currently international health activities are-split among 23 different Federal agencies, each acting independently. Legislative restrictions limiting the involvement of Federal agencies in international health matters must also be removed.

(2) Support a greatly expanded research effort to conquer the major infectious diseases of the world, including immunological research on vaccines and diagnostic tests, the development of more effective drug therapies, and the discovery of better techniques of controlling disease-bearing insects and other vectors.

(3) Give greater assistance to the LDCs in developing better primary health care programs, with a strong emphasis on preventive medicine and basic care delivered by auxiliary health workers within the community.

(4) Establish regional research and training centers in tropical medicine in many of the less developed countries, in full partnership with the foreign governments. The need for a greatly expanded corps of specialists and researchers in tropical medicine cannot be met by existing programs in either the US or foreign medical schools. Much of the medical education in many LDCs is now based on the Western model and has little relevance to the health needs of the majority of people in those countries.

(5) Establish an International Health Service (similar to our domestic National Health Service Corps) to encourage American doctors to begin careers in the area of international health. A program of loan-forgiveness could be used as an incentive. Passage of the bill introduced by Senator Javits (R-NY) providing for short-term service abroad by mid-career health professionals is an important first step.

(6) Give greater assistance to LDCs in mounting mass vaccination campaigns against measles, poliomyelitis, diphtheria, pertussis, tetanus, and tuberculosis. The cost of immunizing a child against these diseases will average only about $3.00 during the next decade, making immunization one of the most cost-effective approaches to reducing illness and death. Today less than 10 percent of the 80 million children born each year in less developed countries are being immunized, and less than $5 million per year is being provided from external sources to expand programs. The WHO Expanded Programme on Immunization has the goal of immunizing all children in the world by 1990, but this will require an expenditure of $150 million a year by the end of the 1980s.

(7) Increase support for food and nutrition programs, emphasizing food production, better distribution, and nutrition education.

(8) Give aid to programs to provide clean drinking water and better sanitation, coupled with health education. The cost of installing community water supplies and sanitation everywhere will be enormous—from $135 to $260 billion by the year 2000, according to the World Bank—but this is an important long-range goal.

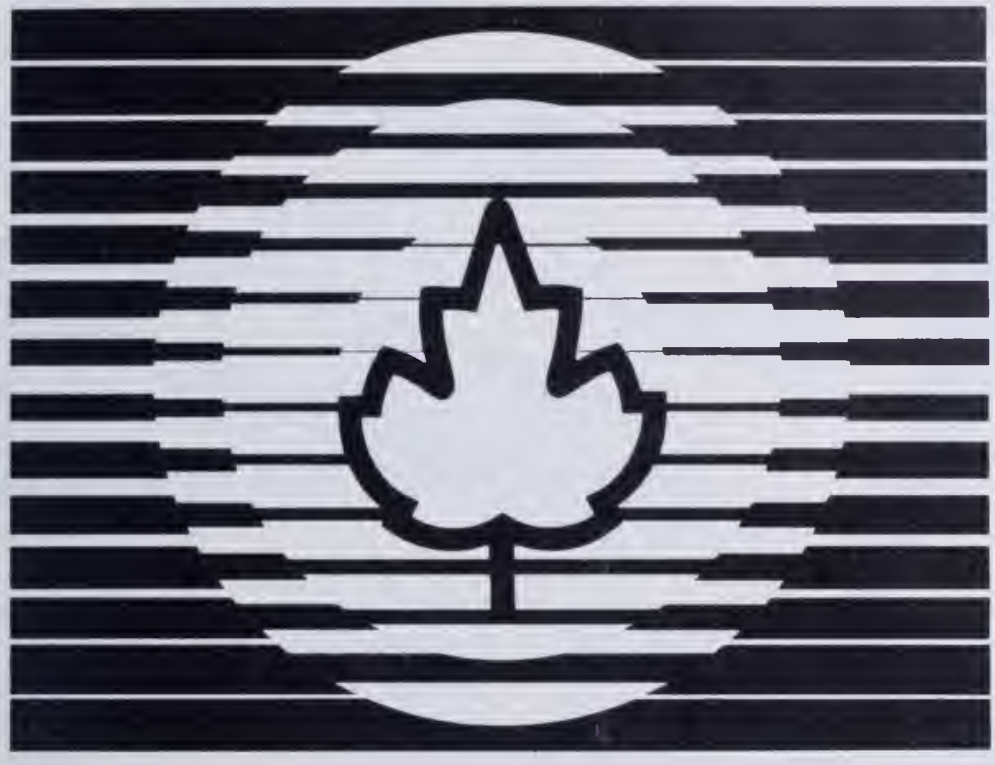
(9) Encourage and support family planning programs in LDCs modeled after the outstandingly successful programs in operation in Taiwan, South Korea, Hong Kong, Java, Sri Lanka, Thailand, and Singapore.

(10) Adopt policies that discourage the "brain drain" of physicians from the LDCs to the United States. A study in 1971 showed that at least 140,000 physicians had left the countries in which they had been born or trained—about 6 percent of the world's total. Most of these physicians came from the less developed countries, such as India, the Philippines, Iran, and Pakistan. Jamaica, Paraguay, Syria, Trinidad and Tobago, Barbados, the Dominican Republic, Guyana, Lebanon, Sri Lanka, and Thailand have lost from one-fourth to one-half of their complement of physicians. Over 90 percent of the migrant physicians moved to developed countries, where the average income of physicians was at least six times higher. Almost half came to the United States.

The quiet holocaust is horrifying, but the world's health situation is not hopeless. Smallpox has been eradicated from the earth through a well organized international campaign conducted at a surprisingly modest cost. Ending smallpox vaccination programs may save worldwide $1 billion a year that can be devoted to other health programs. The research and development costs for the new pneumococcal vaccine were only $3-4 million. We can enjoy similar successes against other diseases in the years ahead if we commit our minds, energies, and financial resources to the fight. A massive effort on the order of our space program that put men on the moon will be needed. Health is a basic human right. We can find no higher goal than the extension of this right to all our brothers and sisters in the world. ■

Good Samaritan Medical Center*

1980 Annual Fall Clinic Day



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Kurt J. Bloch, M.D.
Professor of Medicine Massachusetts General Hospital — Harvard Medical School, Chief, Clinical Immunology and Allergy Units, Massachusetts General Hospital, Director, American Board of Allergy and Immunology

Rebecca H. Buckley, M.D.
Chief, Division of Pediatric Allergy, Immunology and Pulmonary Diseases, Duke University Medical Center, J. Buren Sidbury Professor of Pediatrics, Duke University Medical Center, Professor of Immunology, Duke University Medical Center

MEDICAL COLLEGE OF WISCONSIN FACULTY:

Robert Keller, M.D.
Associate Professor of Pediatrics, Medical College of Wisconsin, Director of Immunology, Midwest Children's Cancer Center, Chief of Immunology, Milwaukee Children's Hospital.

Robert W. Lightfoot, Jr., M.D.
Associate Professor of Medicine, Medical College of Wisconsin, Chief of Rheumatology, Milwaukee County Medical Complex and Veterans Administration Medical Center, Director, Arthritis Center of Southeastern Wisconsin.

PROGRAM:

12:30-12:45 p.m. Introductory remarks by Dr. James Ziolkowski, Chief of Staff Lutheran Hospital and Dr. William Janssen, Chairman, Fall Clinic Day.

12:45-2:00 p.m. Lymphocytes: T-cells, B-cells, Structure, Function and Interaction: Concordance with Clinical Disease (Dr. Kurt Bloch)

2:00-3:00 Immune Deficiency Diseases Due to T and B Cell Abnormalities (Dr. Rebecca H. Buckley)

3:00-3:15 p.m. Coffee Break

3:15-4:00 p.m. Tissue Injury Diseases Due to Immune Complexes: SLE, Rheumatoid Arthritis, Polyarteritis and Others (Dr. Robert Lightfoot)

4:00-5:00 p.m. IgE Antibody-Mast Cell Mediator Systems: Asthma, Anaplylaxix, Hayfever and Others, Interferon and Transfer Factor (Dr. Robert Keller)

5:00-5:30 p.m. General Panel Discussion — Questions and Answers

6:00 p.m. Cocktail Reception

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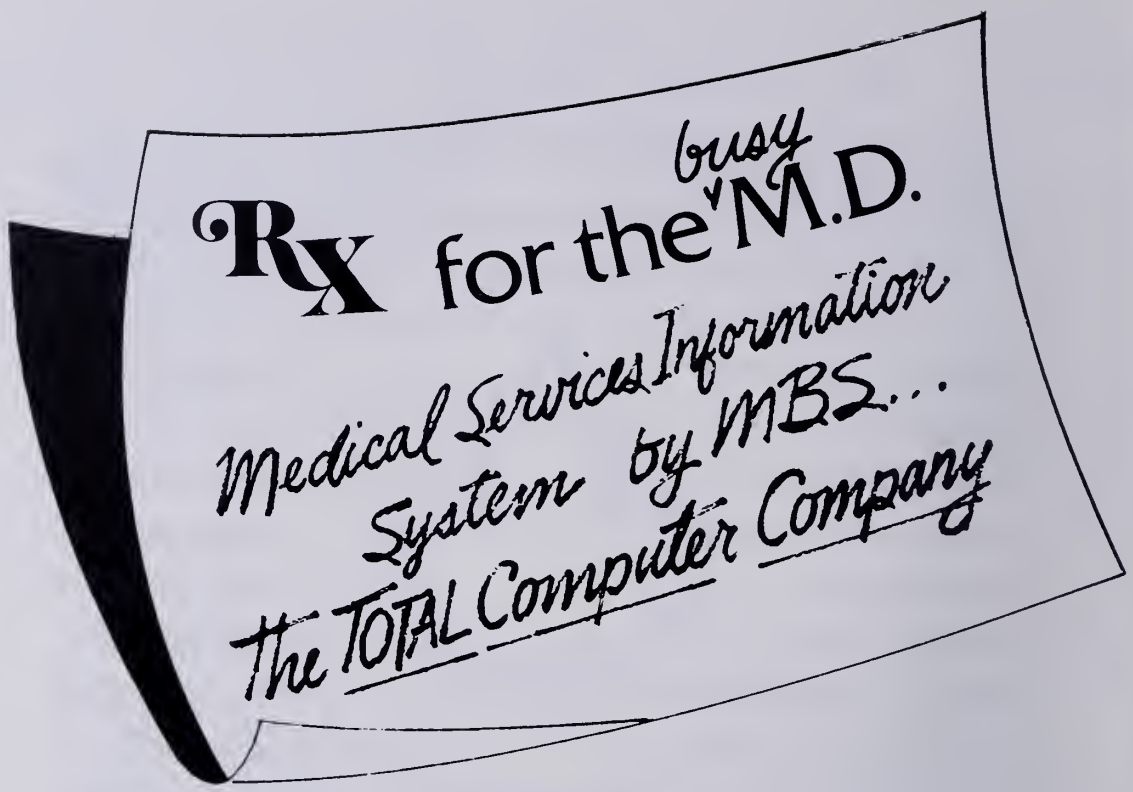

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Scientific Medicine

REFER TO—Fye WB: Echocardiography—1980: Indications and usefulness. *Wisconsin Med J* 79:19-22 (Sept) 1980

KEY WORDS—Echocardiography, cardiologic evaluation technique

Echocardiography—1980: Indications and usefulness

W Bruce Fye, MD,
Marshfield, Wisconsin

One of the most valuable technological developments in medical diagnosis in recent years is echocardiography. This article provides an up to date summary of the indications for obtaining an echocardiogram and reviews those settings in which it is particularly useful.

OVER THE PAST decade echocardiography has become a widely used procedure in clinical medicine. Moreover, the diagnostic capabilities of this technique have recently been dramatically extended and refined with the development of cross-sectional or two-dimensional echocardiography (hereafter, 2DE). With the development of 2DE, a tomographic type image is obtained by moving the ultrasound beam either mechanically or electronically to produce a pie-shaped or wedge-shaped view of the heart[1,2] (Figs 1, 2). There are numerous advantages to this refined technique. The most obvious is the ability to image the entire heart (all four chambers) simultaneously and the improved appreciation of spatial relationships this affords. Several recent publications deal extensively with the principles and technique of obtaining and interpreting an echocardiogram, and the interested reader is referred to them.[3,4]

A fundamental difference between echocardiography and other techniques used to visualize the cardiac structures is the difference between seeing the motion of the valves or walls themselves contrasted with the silhouette or shadow image which is obtained from a traditional chest roentgenogram, angiocardiogram, or nuclear gated blood pool scan. With the echocardiogram the cardiac valve leaflets are visualized, patterns of wall motion are apparent, and wall thickness and chamber dimensions can be measured. Although information about only one specific aspect of cardiac structure or function may be desired by the physician requesting the test, when an echocardiogram is properly recorded and interpreted, a wealth of potentially useful clinical information is obtained.

HEART MURMURS AND VALVULAR HEART DISEASE. Echocardiography is an extraordinarily valuable tool in deciding whether a heart murmur is innocent or significant. It will frequently aid the clinician in defining the origin of the murmur. This is particularly true when auscultation accompanies the echocardiographic examination and if phonocardiography is used with discretion. The total noninvasive evaluation of the patient by a physician utilizing all of these modalities increases the likelihood of a definitive explanation for a heart murmur. Valvular abnormalities of a congenital or acquired sort may be characterized by echocardiography with important clinical implications. It is becoming increasingly apparent that congenitally deformed aortic valves (often bicuspid) are not uncommon, and their natural history is one of accelerated degeneration leading to aortic stenosis or insufficiency in a significant percentage of patients.[5] Some patients with myxomatous degeneration of the mitral valve and mi-

Doctor Fye is Director, Cardiographics Laboratory, The Marshfield Clinic, Marshfield, Wisconsin. Publication support provided. Reprint requests to: W Bruce Fye, MD, Dept of Cardiology, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449 (phone: 715/387-5258).
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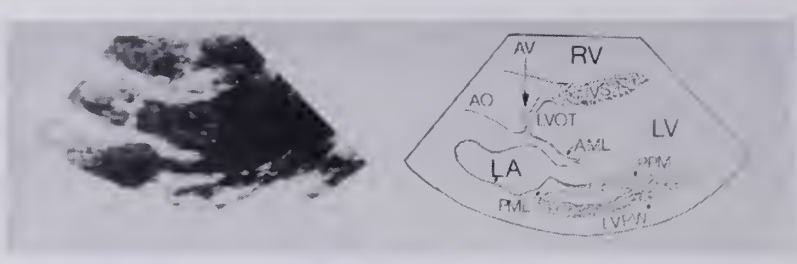

***Figure 1**—Two-dimensional echocardiogram. Parasternal long axis view. The apex of the heart is on the right. Abbreviations: AO = aortic root, AV = aortic valve, LA = left atrium, PML = posterior leaflet of the mitral valve, AML = anterior leaflet of the mitral valve, LVOT = left ventricular outflow tract, IVS = interventricular septum, RV = right ventricular cavity, LV = left ventricular cavity, LVPW = left ventricular posterior wall, PPM = posterior papillary muscle.*

***Figure 2**—Two-dimensional echocardiogram. Apical four chamber view. The apex of the heart is at the top of the diagram. Abbreviations: LV = left ventricular cavity, RV = right ventricular cavity, LA = left atrium, RA = right atrium, MV = mitral valve, TV = tricuspid valve, IVS = interventricular septum.*

tral valve prolapse (floppy mitral valve syndrome) develop disruption of valvular function leading to hemodynamically significant mitral regurgitation.[6] Both of these lesions are associated with an increased risk of infective endocarditis. The severity of valvular involvement secondary to rheumatic heart disease may be assessed echocardiographically. Mitral stenosis may be identified and the 2DE permits a semi-quantitative estimate of mitral valve area.[7] Equally important, the technique may exclude rheumatic heart disease in some patients with murmurs revealing instead mitral valve prolapse or no evidence of significant valvular disease. The implications in terms of prognosis and clinical management of the individual patient are obvious. Furthermore, the hemodynamic effects of valvular lesions can be qualitatively assessed. Unexpected coexistent lesions either of other cardiac valves or of the myocardium may be discovered. Valvular calcifications can be detected with more specificity and sensitivity than by plain chest roentgenography or fluoroscopy. Idiopathic hypertrophic subaortic stenosis (IHSS), also called hypertrophic obstructive cardiomyopathy (HOCM), is a disease which has been identified with increasing frequency by echocardiography, the most sensitive technique for its detection.

CARDIOMEGALY AND LEFT VENTRICULAR FUNCTION. Cardiac dimensions may be assessed more quantitatively than is possible with any other technique at the present time. Cardiomegaly is a common clinical problem. Barium swallow and fluoroscopy are now obsolete since these indirect assessments of cardiac chamber size have been replaced by echocardiography which can give quantitative information regarding specific chamber dilatation and can exclude pericardial effusion or ventricular hypertrophy as causes of cardiomegaly. The dimensions of each of the four cardiac chambers can be assessed thereby suggesting specific pathologic entities. Some estimation of the hemodynamics which have lead to this dilatation can be inferred from the echocardiogram. A characteristic pattern of mitral or tricuspid valve closure is present when there is elevated end diastolic pressure in either ventricle. Hyperkinetic wall motion of various cardiac chambers is present when volume loaded situations of an acute nature are present such as acute aortic insufficiency or acute mitral regurgitation.

Semi-quantitative assessment of left ventricular function is generally sufficient for decision making in clinical practice and echocardiography provides this information.[8] 2DE will undoubtedly come to play an ever-increasing role in the evaluation and management of patients with ischemic heart disease.[9] Regional wall motion abnormalities such as localized hypokinesis and abnormal thinning of ventricular muscle may be detected by this technique thereby suggesting prior ischemic damage of the myocardium. There is growing evidence that 2DE can play an important role in the evaluation of the patient who has had a myocardial infarction.[10] Left ventricular aneurysms can be identified; and because the technique permits the differentiation of the walls of the heart from the blood pool within, echocardiography has a high potential for identifying intracavitary clot.[11] Congestive cardiomyopathy can be differentiated from cardiomegaly of other

etiologies. In this situation cardiac catheterization may be avoided if the echocardiographic picture is classic.

MISCELLANEOUS CONDITIONS. Echocardiography is currently the most sensitive technique for detecting pericardial fluid. The location and quantification of pericardial fluid is possible, particularly with 2DE.[12] Pericardial thickening and calcification may also be identified. Abnormalities of the motion of the interventricular septum and other cardiac structures may suggest constrictive pericarditis or hemodynamically significant pericardial effusion. Although cardiac tamponade may be suggested by echocardiography, it is necessary to correlate the amount of pericardial fluid visualized with the clinical and hemodynamic status of the patient.

Atrial myxomas, the most common primary cardiac tumor, are being identified with increasing frequency in response to the growing utilization of echocardiography.[13] 2DE has led to the discovery of clinically occult right-sided cardiac tumors not easily visualized by M-mode echocardiography. Valvular vegetations in infective endocarditis may be identified and characterized by echocardiography.[14] As experience with 2DE in endocarditis grows, it may be possible to subdivide patients into high and low risk groups for embolization in this setting. In this way earlier surgical intervention in patients with marginal hemodynamic states may be considered. Peripheral embolization either to the central nervous system or other parts of the body may be on the basis of occult intracardiac tumor or thrombus in the setting of an unsuspected myocardial infarction or valvular heart disease. Although these causes for peripheral emboli are relatively unusual, the therapeutic implications in each of these instances are significant and echocardiography should be considered in patients with emboli who do not have an obvious extracardiac source. The proximal ascending aorta may be visualized by the technique, aneurysms may be identified, and if immediate surgical intervention is not felt necessary, they may be followed echocardiographically.[15]

CONGENITAL HEART DISEASE. Although this review deals primarily with the usefulness of echocardiography in the adult population, some mention of the valuable role it plays in congenital heart disease is necessary. Echocardiography, especially 2DE, has revolutionized the practice of pediatric cardiology and plays an important role in detecting and defining congenital heart disease in the adult population. A more logical decision about the necessity and timing of invasive evaluation of patients with suspected or known congenital heart disease can be made on the basis of echocardiographic findings in most cases. This is particularly important when one is considering catheterization in young individuals in view of the radiation exposure that this procedure necessitates. Contrast echocardiography utilizing saline injection into a peripheral vein gives additional information in complex congenital heart disease in the cyanotic patient.[16,17]

PREGNANCY. Pregnancy is a situation which deserves special comment. It is not infrequent that murmurs develop during the course of normal hemodynamic response to pregnancy. Also, with progressive elevation of the diaphragms and increase in intravascular volume, cardiomegaly may appear. It is not desirable to expose the fetus to unnecessary radiation so echocardiography may be very useful in determining whether murmurs or cardiomegaly discovered or appearing during pregnancy are of significance or whether they are merely a physiologic response to the pregnant state.

IS CONSULTATION OR INVASIVE EVALUATION NECESSARY? The primary care physician is frequently confronted with nonspecific cardiac complaints or physical findings and will often find the echocardiogram useful in deciding which individuals should be referred for formal cardiologic evaluation. Echocardiography can help the consultant decide on the necessity of cardiac catheterization and plan the timing of this procedure.

SCREENING SELECTED PATIENTS WITH ECHOCARDIOGRAPHY. Are there situations where echocardiography should be employed as a screening procedure? The question of utilizing any diagnostic test or procedure in a screening fashion is controversial. The justification for this depends upon such questions as cost, safety, sensitivity, specificity, predictive value, and prevalence of disease conditions in the population being studied.

In patients *with known or suspected cardiac disease,* therapeutic decisions often may be made more rationally once echocardiographic information is combined with the data acquired through a careful history, physical examination, and traditional laboratory modalities. At this point one can comfortably say that an echocardiogram is an important part of the cardiac evaluation of any adult patient with a heart murmur. If the echocardiogram is entirely normal, one can reassure the patient that the course of the murmur is likely to be benign. On the other hand, occult cardiac conditions such as idiopathic hypertrophic subaortic stenosis, mitral valve prolapse with atypical auscultatory phenomena among other disease entities may be detected and the course and prognosis

more accurately defined by proper identification. As technology develops and clinical experience with 2DE increases, it is likely that patients with coronary artery disease and its complications (angina pectoris, myocardial infarction and its consequences) will form another subset of patients routinely examined echocardiographically prior to invasive evaluation.

SERIAL ECHOCARDIOGRAMS. The question of serial echocardiograms is understandably controversial. Certainly, there is no justification for repeating an echocardiogram in patients who have had a normal echocardiographic study if their clinical course is benign and no new cardiac symptoms or signs have appeared. On the other hand, this noninvasive modality is particularly valuable in following patients with known valvular heart disease in order to assess longitudinally the hemodynamic consequences of the pathologic process. Pericardial effusion with its potential complications of constrictive pericarditis or pericardial tamponade form another area where serial echocardiographic studies may well be indicated. Obviously, the frequency of such serial examinations depends upon the clinical course and underlying disease process.

SUMMARY. Echocardiography has been a dramatic development in medicine and cardiology. It has enabled the physician to decide more readily if cardiac disease is present; and if so, to plan further diagnostic tests or definitive treatment more rationally. It can be expected that M-mode echocardiography will be in widespread clinical use within the next few years and 2DE will be available in all larger medical centers where the patient load and availability of skilled personnel justifies the purchase and utilization of the equipment.

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Abstracts

Infections caused by arterial catheters used for hemodynamic monitoring

JEFFREY D BAND, MD and DENNIS G MAKI, MD (University of Wisconsin hospitals, Center for Health Sciences, Madison, Wis): *Am J Med* 67:735-741 (Nov) 1979

Utilizing a semiquantitative technique for culturing vascular catheters, the authors prospectively studied the risk and profile of infection caused by arterial catheters used for hemodynamic monitoring in 95 patients with a high risk of nosocomial infection. Of 130 catheters, 23 (18 per cent) produced local infection ($\geq$ 15 colonies on semiquantitative culture) and five septicemia (4 per cent). Sixteen of the 23 local infections and all septicemias occurred with catheter placements exceeding four days ($p < 0.001$). Other factors associated with an increased risk of infection included insertion by surgical cut-down rather than percutaneously (ninefold increased rate of bacteremia, $p = 0.008$) and the presence of local inflammation (12-fold increase, $p = 0.009$). Systemic antimicrobial therapy (given to 80 per cent of the entire group and to four of the five with septicemia) did not protect against catheter-related infection but may account for the predominance of enterococci, Candida and gram-negative bacilli in these infections. Twelve per cent of all nosocomial bacteremias occurring in this critical care unit population originated from an arterial catheter. Indwelling arterial catheters pose a significant risk of bacteremic infection to critically ill patients. The percutaneous mode of placement is preferred; when prolonged arterial cannulation is required, the site should be rotated every four days. Local pain or inflammation, or clinical signs of sepsis without an obvious source should prompt removal and culture of the catheter. ■

REFER TO—Kubiak MK, Dedmon RE, Gander JW, and Paschke AC: Coronary risk factor screening in an industrial health management program in Wisconsin. *Wisconsin Med J* 79:23-25 (Sept) 1980

KEY WORDS—Coronary heart disease, multiphasic screening, health maintenance

Coronary risk factor screening in an industrial health management program in Wisconsin

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EMPLOYEE HEALTH has become a major concern in industry because of the escalating cost of health care. In the past decade, some companies have established health maintenance programs with the objectives of increasing productivity and decreasing absenteeism and loss of personnel from death or disability. Coronary heart disease, because it causes the highest mortality and morbidity among employed adults, has become the prime target for these health programs. In addition, there is evidence that a Heart Disease Control Program can be cost-effective.[1]

Kimberly-Clark Corporation began its Health Management Program in April 1977 for salaried employees in the Fox Valley of Wisconsin. From April 1, 1977, until August 15, 1978, 1,446 employees (959 men, 487 women) who wished to participate were given multiphasic screening and physical examinations, plus an exercise electrocardiogram with a treadmill or bicycle ergometry. The multiphasic screening consisted of a blood pressure recording, height and weight measurements, hearing and vision tests including measurement of intraocular tension, spirometry, percentage of body fat as measured by skin fold and/or submersion, chest x-ray, complete blood cell count, urine test, a blood chemistry-panel and measurement of high density lipoprotein (HDL) cholesterol levels.

Entry data were collected from the multiphasic screening of these employees during the 17½-month period from April 1, 1977, to August 15, 1978. This article describes findings from the multiphasic screening and focuses on risk factors for coronary heart disease. The entry level data from Kimberly-Clark employees are of interest because they give information on risk factors for coronary heart disease in individuals in an industrial screening program. Immediate results of the screening found five asymptomatic employees with serious heart disease: three required bypass surgery and two had valve replacements. Cancer was detected in six employees (0.4%) which is similar to the national figure for new cases of cancer (0.3%) diagnosed in 1977.[2]

Ten percent of the employees had abnormal exercise electrocardiograms. The rate of false positive treadmills is known to be high, especially in women. To obtain better sensitivity and specificity, thallium scans[3] and gated wall motion studies[4] are being performed on a number of employees. This study is in progress and will be reported in the future.

Of the 1,446 employees screened, 3.4% of the men and 1.4% of the women were found to have three or more risk factors for coronary heart disease. Males and females 60+ years old were the largest group showing at least one risk factor.

HYPERTENSION. Our health screening program identified 12.1% of the men and 4.9% of the women as having a systolic blood pressure over 140 mm of mercury.* The National Health Survey 1975 listed the national average for hypertension as 15%.[5] Those employees who were found to have elevated blood pressure were monitored by occupational health nurses; and if their blood pressure remained elevated, they were referred to their personal physician for further evaluation and treatment. Those who had a hypertensive blood pressure response during the treadmill or bicycle ergometry test also were referred to their personal physician.

The prevalence of hypertension varies depending on the criteria used. The World Health Organization defines hypertension as a diastolic blood pressure greater than 95 mm of mercury.[6] In the Community Hypertensive Evaluation Clinic (CHEC) Program,[7] with the criterion of 90 mm of mercury diastolic blood pressure, the prevalence was 24.7%; and, with 95 mm of mercury, it was 11.6%. In the Milwaukee Hypertensive Screening Study,[8] the prevalence was 22.3% with

From the Corporate Health Services Department of Kimberly-Clark Corporation, Neenah, Wisconsin. Doctor Kubiak is director, clinical staff; Doctor Dedmon is staff vice president for medical affairs; Mr Gander is senior research scientist; and Ms Paschke is technician. Publication support provided. Reprint requests to: Mary K Kubiak, MD, Director, Clinical Staff, Kimberly-Clark Corp, Neenah, Wis 54956 (phone 414/729-1212). Copyright 1980 by the State Medical Society of Wisconsin.

*Tables are available upon request to the authors.

diastolic levels of 90 mm of mercury and 10.8% with diastolic levels 95 mm of mercury. In the Kimberly-Clark Screening Program, the prevalence, using the criterion 90 mm of mercury, was 12.4% and, with 95 mm of mercury, it was 7.6%. In Kimberly-Clark employees, as in the other two national screening studies, the prevalence of hypertension generally increased with age and was significantly higher ($P<0.005$) in men than women.

SMOKING. It was found that 18% of the employees smoked one package of cigarettes or more per day while the Health Interview Survey for 1975 listed the national smoking prevalence as 34%, with about 22% of smokers smoking 25 or more cigarettes daily.[9] The 1978 Health Interview Survey indicated a prevalence of 34% for smoking, with about 10% smoking 25 or more cigarettes daily.[10]

HYPERCHOLESTEROLEMIA. Americans derive 40% of their total calories from animal fat. One of the goals of the Senate Select Committee on Nutrition is to reduce animal fat in the diet in order to decrease blood lipids and the risk for coronary heart disease. Although there is controversy about the diet-lipid hypothesis,[11] the Framingham Study did identify elevated serum cholesterol as a risk factor for coronary heart disease.

In our group a total of 44.9% of men and 30.6% of women had cholesterol levels above 240 mg/dl.* The observation that 20.1% of males and 13.1% of females in the 18-29-year-old group had cholesterol levels higher than 240 mg/dl is of concern because of the tendency of serum cholesterol to rise with age.

The highest groups with elevated cholesterol levels were men 50-59 years and women 60+ years. Women showed a sharp rise in their 50s. Another study done in Evans County, Georgia,[12] showed that about 22% of the population had cholesterol levels of over 240 mg/dl. It may be that a Wisconsin diet high in dairy products plays a part in this high prevalence of elevated cholesterol in our screening program.

HDL CHOLESTEROL. HDL cholesterol is thought to be a protective factor against coronary heart disease.[13] In our group the HDL cholesterol level of men and women who smoked was less than in those who did not (Table 1). In addition, women who did not smoke and were on oral contraceptives had a higher HDL (67.8 mg/dl) than those who smoked and used oral contraceptives (63.8 mg/dl) (Table 1) although this was not statistically significant. This finding was also noted by Bradley, et al,[14] in a group of women using oral contraceptives. He noted that HDL levels increased with estrogens and decreased with progestins. Women in the Kimberly-Clark study who smoked and were not on oral contraceptives had a lower HDL cholesterol level than those who did smoke and were also on oral contraceptives, but this difference was not statistically significant.

OBESITY. The average relative weight of all age groups (men and women) was well in excess of 100 percent.* Kimberly-Clark male employees had higher relative weights than those in the Pooling Research Project.[15]

DISCUSSION. Presently under way are a number of large studies to modify risk factors in coronary

Table 1—Relationship between sex, oral contraceptive usage, and smoking and HDL cholesterol levels.

RELATIONSHIP OF SMOKING AND SEX TO HDL CHOLESTEROL (men and women, ages 18 to 78)

	WOMEN			MEN			MEN AND WOMEN	
	Number	Mean HDL cholesterol (mg/dl)	SD	Number	Mean HDL cholesterol (mg/dl)	SD	Number	Mean
Nonsmokers	398	70.1	± 18.5	785	56.7	± 15.5	1,183	61.2
Smokers	89	61.3	± 14.1	174	53.8	± 14.5	263	56.3

Means for men and women differ significantly ($P<0.01$)
Means for nonsmokers and smokers differ significantly ($P<0.05$)

RELATIONSHIP OF SMOKING AND ORAL CONTRACEPTIVE TO HDL CHOLESTEROL (women, ages 18 to 49)

	NO ORAL CONTRACEPTIVE			ORAL CONTRACEPTIVE		
	Number	Mean HDL cholesterol (mg/dl)	SD	Number	Mean HDL cholesterol (mg/dl)	SD
Nonsmokers	228	69.6	± 17.8	90	67.8	± 18.2
Smokers	52	59.9	± 12.6	20	63.8	± 13.9

Means for nonsmokers and smokers differ significantly ($P<0.01$) for nonuse of oral contraceptives. Other differences between smokers versus nonsmokers, and oral contraceptive versus no oral contraceptive are not significant.

HDL = High density lipoprotein

heart disease, including MRFIT—The Multiple Risk Factor Intervention Trial[16]—and the Stanford Heart Disease Prevention Program.[17]

One of the aims of the Kimberly-Clark Health Management Program, as well as the larger studies, is to motivate employees to change their lifestyles in a way that will modify or reduce their risk factors for coronary heart disease. Although there is already a downward trend in coronary heart disease in the United States which has not been seen in other industrial nations, the final mortality statistics for 1977 showed that diseases of the heart were the leading causes of death in the United States, responsible for four out of every ten deaths. Eighty-eight percent of the deaths in this category were due to coronary heart disease.[18,19]

One difficult problem remaining to be resolved is the use of treadmill testing as a screening tool. In an asymptomatic population its predictive value is low.[20] However, we have found treadmill testing good for estimating fitness levels as a basis for exercise prescriptions, although relatively inefficient. The treadmill test also has been a useful motivational tool for monitoring employees' progress in our exercise program. Whether radionucleotide exercise studies will be of assistance remains to be seen.[21]

The data we have collected during the first 17½ months of the Kimberly-Clark program give the baseline for future evaluation of the success of our effort to decrease coronary risk factors in our employees and to ultimately contribute to health cost containment and the control of absenteeism. The proof remains to be documented and probably will require ten years of evaluation and cost-benefit analysis.

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Abstracts

The bacterial defect of neutrophil function with lithium therapy

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In: *Lithium Effects of Granulopoiesis and Immune Function, Advances in Experimental Biology and Medicine,* A H Rossof and W A Robinson (eds), Plenum Press, vol 127, pp 389-399, 1980

In preliminary studies eight normal volunteers were studied before and after 1 week of lithium therapy. A battery of tests of granulocyte, lymphocyte, and platelet function were performed. Granulocyte function tests included random mobility, chemotaxis, phagocytic and bactericidal indices, nitroblue tetrazolium (NBT) reduction, chemiluminescence, and skin windows. Lymphocyte function included T and B cell enumeration, lymphocyte transformation to mitogens and antigens. Platelet aggregation studies and Ivy bleeding times assessed platelet function. Except for a significant reduction in bactericidal capacity ($P < 0.005$) and lymphocyte response to PPD ($P < .01$), all studies were not significantly affected by the lithium. Subsequent studies of patients on long term lithium therapy confirmed the defect of neutrophil bactericidal capacity in three out of four patients, but failed to reveal any defect in lymphocyte response. When lithium was incubated with whole blood *in vitro* at final concentrations varying from 1 mEq/l to 50 mEq/l, no alteration of histochemical stains for neutrophilic myeloperoxidase or alkaline phosphatase activity was observed. There is a reduction of bactericidal capacity in patients treated with lithium, but the mechanism and clinical significance of this defect is unclear. ■

REFER TO— Gallagher WB: Normal appendectomies. *Wisconsin Med J* 79:26-27 (Sept) 1980

KEY WORDS—Appendicitis

Normal appendectomies

William B Gallagher, MD, LaCrosse, Wisconsin

BETWEEN 1973 and 1978, 701 patients were operated for acute appendicitis. Of these 601 showed catarrhal, suppurative, gangrenous, or perforating appendicitis. One hundred (14%) appeared normal histologically; *ie,* they did not show the changes of acute appendicitis.

Most of these 100 patients, erroneously diagnosed as having appendicitis, were young women.

1. Gynecologic disorders. Two had acute salpingitis (PID), five had ovulatory bleeding (Mittelschmerz) and four were in their middle trimester of pregnancy.

2. Diverticulitis, cholecystitis. One 56-year-old woman had a perforating Meckel's diverticulitis due to an ingested fish bone. A 54-year-old man had gangrenous cholecystitis in a low-hanging gallbladder. A 64-year-old man had perforating diverticulitis in his sigmoid colon which pointed to the right lower quadrant.

3. Regional enteritis. Five patients had regional enteritis instead of appendicitis. Nineteen had enlarged lymph nodes in the mesentery of their terminal ileum. Is "mesenteric adenitis" a real entity? It has been associated with Coxsackie A virus enteritis and the Pasteurella organisms *Yersinia enterocolitica* and *pseudotuberculosis.* The few cultures on peritoneal fluid on these mesenteric lymphadenitis patients were negative.

Blattner[1] says ". . . surgical intervention in mesenteric lymphadenitis is . . . less hazardous than the rupture of an . . . inflamed appendix."

4. Periappendicitis. The pathologists reported "periappendicitis" in 17 of our 100 patients; seven of these were clearly secondary to inflammatory disease elsewhere in the abdomen, ten were "primary" periappendicitis. These patients recovered from their operations with no signs of missed disease surfacing.

Table 1—Sex and age of appendectomy patients with normal appendices

Age (decades)	*Sex*		*Number of patients*
	Male	*Female*	
0-10 years	5	9	13
10-20 years	15	34	49
20-30 years	6	23	29
30+ years*	3	5	8
Total	29	71	100

*The oldest patient was a 64-year-old man with sigmoid diverticulitis.

Many consider this condition a nonpathologic entity, while others believe it represents the earliest form of acute appendicitis (Cunningham[2]).

5. Fecaliths and pinworms. The surgeons noted fecaliths in the appendices of seven patients out of these 100. Two had pinworms. Tolstedt reported on 20 patients (mostly children) operated for right lower quadrant abdominal pain and found to have pinworms in their otherwise normal appendices. Eighteen were completely relieved of their preoperative symptoms.

6. Chronic appendicitis. Savrin, at Ohio State, found 16 persons with chronic, recurrent or subacute appendicitis among 225 appendectomy patients. We had two such patients, a 21-year-old woman and a 12-year-old boy, both of whom had had right lower quadrant pain off and on for six weeks to three months, relieved by appendectomy.

7. Systemic illnesses. Fourteen patients presented with right lower quadrant pain and tenderness with various systemic illnesses—pyelonephritis, tonsillitis, gastroenteritis, pneumonia, and flu syndrome. These patients recovered from their appendectomies and also their primary disease.

8. No disease. Thirty-seven of the 100 patients came to appendectomy with no disease discovered, then or later. All recovered without short-term detriment.

9. Perforative appendicitis. During this period we operated on 77 patients with perforative appendicitis. In three of these we procrastinated before operating, being unable at first to establish a diagnosis.

Abstracted from a paper presented at the September 1979 fall meeting of the Wisconsin Surgical Society. Reprint requests to: William B Gallagher, MD, Department of Surgery, Skemp-Grandview-LaCrosse Clinic Ltd, 815 South Tenth St, LaCrosse, Wis 54601 (Phone: 608/782-9760). Copyright 1980 by the State Medical Society of Wisconsin.

These patients all recovered, but morbidity was high and our incidence of either wound or intraabdominal abscess was 28%.

DISCUSSION. None of these 100 patients operated erroneously for appendicitis died. Three developed wound abscesses, although they were "clean" cases. One patient diagnosed periappendicitis had a repeat negative laparotomy one year later for abdominal pain.

Sixty-three patients had some disease process, co-existing with their symptom of right lower quadrant pain and findings of right lower quadrant tenderness, leaving 37, or 37% with no explanation for their clinical picture of acute appendicitis.

The preponderance of normal appendices from young females (71 of these 100 patients) suggests that in case of doubt in girls and young women with right lower quadrant pain and tenderness, we should procrastinate.

CONCLUSIONS. Salpingitis, ovulatory bleeding, Meckel's diverticulitis, regional enteritis, mesenteric lymphadenitis and sigmoid diverticulitis can simulate appendicitis.

Right lower quadrant abdominal pain and tenderness, anorexia, fever and leukocytosis occur in normal uterine pregnancies, especially in the middle trimester.

Periappendicitis, either secondary to systemic disease (tonsillitis, pyelonephritis) or intraabdominal disorders (salpingitis, regional enteritis, Meckel's diverticulitis, sigmoid diverticulitis) or as an apparently primary condition (local peritonitis) either simulates appendicitis or is an early stage of it.

Fecaliths and pinworms in the appendix can produce the clinical picture of appendicitis.

Chronic, recurrent, or subacute appendicitis exists.

Sometimes we find no local or systemic explanation for a patient with anorexia, right lower quadrant pain and tenderness, leukocytosis, and fever. Laparotomy and appendectomy is a reasonable and safe preocedure in such patients, in the absence of contraindications to surgery and anesthesia.

SUMMARY. Appendicitis may not be entirely a histologic diagnosis.

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Abstracts

Simple protective isolation in patients with granulocytopenia

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Reprinted from Current Chemotherapy and Infectious Disease Proceedings of the 11th ICC and the 19th ICAAC *Am Soc Microbiol*, 1980

Infection, often nosocomial, is a major cause of morbidity and mortality in patients with granulocytopenia. Although most infections in these patients are believed to be of endogenous origin, there is evidence to suggest that many derive from colonization by nosocomial pathogens. Elaborate programs of environmental protection, which have included filtered air, sterilization of all food stuffs, continuous administration of prophylactic nonabsorbable antibiotics, and regular applications of mucocutaneous disinfectants, have shown benefit in terms of reduction of infection in well-controlled studies, but inconsistent improvement in leukemic remissions or survival. Since this degree of environmental protection is logistically and economically prohibitive for most hospitals, simple protective isolation (PI), as defined by the Center for Disease Control—requiring a single room and that all persons entering the room wear a gown, head cover, gloves, and mask—is used in many hospitals on the assumption that these more modest measures are possibly of some benefit. The authors undertook a controlled comparative study to determine whether this less stringent form of environmental protection is of value.

They concluded that more modest forms of environmental protection, *eg*, the simple PI practiced in most hospitals, offer no significant benefit to granulocytopenic patients. When balanced against its cost, the potential adverse pyschosocial effects it has on patients, and the greatly increased demands it places on the delivery of optimal nursing and medical care, simple PI bears critical reevaluation. ■

ELECTROMYOGRAPHIC STUDIES continued from page 30

To our knowledge this is the first case of foramen magnum meningioma that has been studied extensively with EMG, CT head scan, and cerebral angiography. It has been documented in the past that abnormalities in the vascular supply are the basis for the lower cervical cord pathology leading to subsequent denervation in the arm muscles. The angiographic findings of displaced anterior spinal artery in our patient probably produced some hemodynamic changes, resulting in a chronic ischaemic state and thus producing the signs of denervation in EMG. ■

REFER TO—Sty JR, Kun LE, Casper JT: Bone scintigraphy in neuroblastoma with ovarian metastasis. *Wisconsin Med J* 79:28-29 (Sept) 1980
KEY WORDS—Neuroblastoma, metastatic, bone-seeking tracers

Bone scintigraphy in neuroblastoma with ovarian metastasis

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The authors describe a child with metastatic neuroblastoma to the ovary which demonstrated abnormal accumulation of ^{99m}Tc-methylene-diphosphonate.

NEUROBLASTOMA is a common solid childhood tumor. About 70% of these tumors occur in the retroperitoneum, half of which arise in the adrenals.[1] The common sites of metastasis include liver, bone, lymph nodes, meninges, and skin.

We recently evaluated a two-year-old female with a right adrenal neuroblastoma which metastasized to the left ovary. The large left ovary was the presenting physical finding. A radionuclide bone scan using 8.3 mCi/m^2 of ^{99m}Tc-methylene diphosphonate demonstrated tracer uptake in the adrenal primary and left ovary, as well as extensive skeletal metastases (Fig 1). An ultrasound examination confirmed a solid retroperitoneal tumor above the right kidney (Fig 2) and a large solid intraabdominal mass (Fig 3). There was no continuity between the masses. Histopathology of the marrow examination revealed neuroblastoma. The child responded well to cyclophosphamide (Cytoxan®) and doxorubicin hydrochloride (Adriamycin ™). After four months of treatment the bone scan showed marked regression of metastases and tumor cells could not be identified in bone marrow aspirations. Subsequently, laparotomy revealed a resid-

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Figure 1—Posterior view. (3 hour delayed ^{99m}Tc-methylene diphosphonate bone image) Open arrow marks metastatic bone lesion, curved arrow marks right adrenal neuroblastoma, and solid arrows mark uptake in ovarian metastasis.

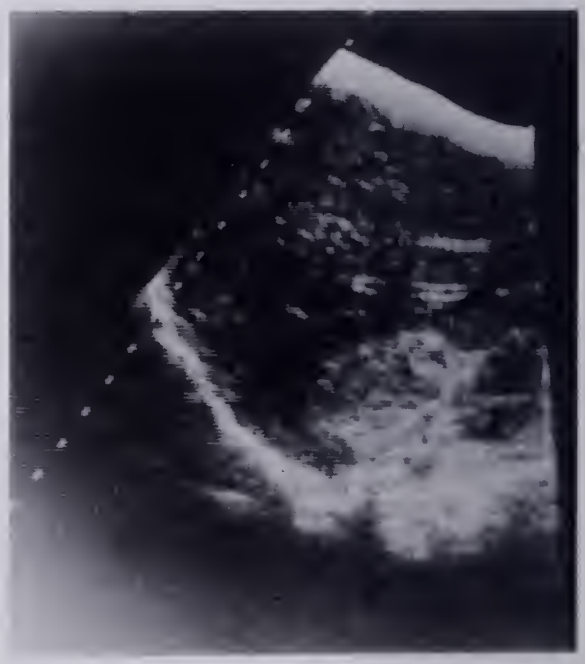

Figure 2—Supine longitudinal ultrasound. Arrow marks solid adrenal tumor. (1) liver (k) kidney.

Figure 3—Supine longitudinal ultrasound. Arrow marks solid intraabdominal mass. (a) aorta (b) bladder.

ual right adrenal neuroblastoma and a single large metastasis in the left ovary.

Metastatic neuroblastoma to the ovary presenting as an abdominal mass is distinctly uncommon. Neuroblastoma arising in a metastasizing ovarian teratoma[2] has been observed, as well as occasional seeding to the ovaries in advanced disease at autopsy.[3]

It is well known that neuroblastoma will accumulate tracer,[4,5,6] and uptake of tracer in the region of the sympathetic nervous system in this age group is almost pathognomic of neuroblastoma.[6] However, we are not aware of a distant metastases to the ovary demonstrating tracer uptake.

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Abstracts

The probability of surviving coronary bypass surgery

RAYMOND G HOFFMANN, PhD; STEVEN L BLUMLEIN, MD: ALFRED J ANDERSON, MS: JOSEPH J BARBORIAK, ScD; JOHN A WALKER, MD; and ALFRED A RIMM, PhD, The Medical College of Wisconsin, Milwaukee, Wis; Wood Veterans Administration Center, Wood, Wis, and St. Luke's Hospital, Milwaukee, Wis: *JAMA* 243:1341-1355, (Apr 4) 1980

This study of 1,718 men with bypass surgery from 1970 to 1974 in Milwaukee has indicated that the following factors are significantly associated with five-year survival: left ventricular end-diastolic pressure (LVEDP), plasma cholesterol level, degree of coronary occlusion, age, and left ventricular function (LVF). The 31 men with a previous stroke had a high risk (five-year survival was 32%). To serve as a guide to patient risk, a logistic model is used to predict five-year survival. These probablities are tabulated for all combinations of LVEDP, age, LVF, degree of occlusion, and plasma cholesterol level. ■

Abstracts

Presented at the Spring Meeting of the Wisconsin Neurological Society
May 9-10, 1980, Madison, Wisconsin

Francis M Forster, MD, Madison, Program Chairman

Sarcoidosis of the nervous system

Jitendra K Baruah, MD, Milwaukee, Wisconsin
Michael P McQuillen, MD, Milwaukee, Wisconsin
A R Sulaiman, MB,BS,FRCP(C), Milwaukee, Wisconsin
W Wong, MD, Milwaukee, Wisconsin
Gregory J Harrington, MD, Milwaukee, Wisconsin
G W Hambrook, MD, Rockford, Illinois

Sarcoidosis involves the nervous system in approximately five percent of cases. However, diffuse involvement of the central and peripheral nervous systems and muscles in a patient are rare. Recently we have seen such a patient with diffuse encephalomyelo-radiculo-neuropathy with inflammatory myopathy, who responded well on prednisone therapy. The diagnosis of sarcoidosis was confirmed on hilar lymph node biopsy. The investigative procedures revealed abnormally slow EEG, with normal computerized tomographic (CT) scan of the head. The cerebrospinal fluid protein was 76 mg/dl with normal cell count. The electromyographic studies revealed evidence of demyelinating neuropathy. The blink reflex studies were compatible with brainstem dysfunction. The sural nerve and muscle biospy confirmed the electromyographic findings.

This case reveals that such a widespread involvement of the nervous system in sarcoidosis is possible. The clinical presentation often may be confusing with various degenerative disorders of the central nervous system. As these cases often show good recovery with steroid therapy, prompt diagnosis and treatment may be rewarding to prevent permanent disability or even death. ■

Overlap syndrome of myopathy and demyelination presenting in two generations of a family

Ian A Wilkinson, MB,FS,FRACP, Milwaukee, Wisconsin
Jitendra K Baruah, MD, Milwaukee, Wisconsin
A R Sulaiman, MB,BS,FRCP(C), Milwaukee, Wisconsin
Herbert M Swick, MD, Milwaukee, Wisconsin

Two brothers developed progressive muscle weakness from age 20 years. The elder was recently examined at age 45. He was confined to a wheelchair, having pseudohypertrophy of calf muscles and moderately severe proximal weakness, more in legs than arms. Ankle clonus was present but other deep tendon reflexes were diminished. He had loss of vibration sense in his lower limbs and urological examination revealed an asensory bladder. Optic atrophy and internuclear ophthalmoplegia were present.

The younger brother was examined at the age of 38. His weakness was in a similar distribution, although less marked, and he had pseudohypertrophy of calves, as well as shoulder and arm muscles. Similar loss of vibration sense was found.

In each brother electromyography suggested a myopathic process, whereas sural nerve biopsies showed evidence of demyelination. In the elder brother a muscle biopsy was consistent with chronic denervation and reinnervation, whereas in the younger the changes were of a myopathic process.

Their mother died at age 59 years after a 25-year history of "multiple sclerosis" and two maternal uncles suffered from "muscular dystrophy."

The patients presented a variation on what was clinically suggestive of the Becker type muscular dystrophy with added features of demyelination, inherited either in an X-linked or autosomal dominant fashion. ■

Electromyographic studies in a case of foramen magnum meningioma

Blas M Zelaya, MD, Milwaukee, Wisconsin
Jitendra K Baruah, MD, Milwaukee, Wisconsin
Michael P McQuillen, MD, Milwaukee, Wisconsin
Ivan Stanko, MD, Wausau, Wisconsin

Tumors in the region of the foramen magnum are known to be associated with atrophy of the small muscles of the hands. There is no absolute specificity, however, to the phenomenon of muscle atrophy. The case of a 52-year-old woman with features of atrophy of the small muscles of the hands and pyramidal signs in all the extremities was presented. The electrophysiological studies revealed normal nerve conduction studies in the upper and lower extremities, whereas needle electromyographic examination had shown widespread evidence of acute denervation of muscles in both upper extremities. The EMG studies in the lower extremity muscles were normal. The computerized tomographic (CT) scan of the head showed an abnormally enhanced mass immediately in front of the medulla. The cerebral angiographic study revealed a vascular blush associated with posterior displacement of the anterior spinal artery at the C_1 and C_{1-2} level. At surgery a large mass (meningioma) was removed from the region. *continued on page 27*

Editor: LUIS B CURET, MD
Professor, Department of Obstetrics and Gynecology
University of Wisconsin Center for Health Sciences
Madison General Hospital, Madison, Wisconsin

REFER TO—Zachman RD: Twins—still a perinatal problem. *Wisconsin Med J* 79:31-32 (Sept) 1980
KEY WORDS—Multiple births, perinatal care, respiratory distress syndrome

Twins—still a perinatal problem

Richard D Zachman, PhD, MD, Madison, Wisconsin

EDITORIAL NOTE: Twin pregnancies continue to be an important cause of perinatal mortality primarily due to prematurity. The accompanying article summarizes our experience at the University of Wisconsin Perinatal Center at Madison General Hospital. It is evident that new approaches are needed if we are to minimize the problem of prematurity associated with twin pregnancies.—LBC

TWIN BIRTHS have been the subject of great interest for centuries and are a cause of concern to those delivering perinatal health care. Many taboos and myths are recorded in writings about twins. For example, Romulus and Remus of ancient mythology were sons of the war god Mars, were saved from a spiteful relative, fed by a mother wolf, raised by a shepherd family, and later founded a great new city, Rome. In various cultures from medieval times, twins have supposedly been related to infidelity, subsequent infertility, good luck and bad luck. In some cultures witchcraft was suspected, and sometimes one or both twins were killed.

In modern times twin births account for a high percentage of overall perinatal mortality. We have recently reviewed our four-year experience with twin births in a Perinatal Center, and the perinatal mortality rate was very high, 125/1000 live births. This is similar to other reports in the literature.[1-4] The perinatal mortality rate for twins is approximately seven to eight times the overall perinatal mortality rate for the South Central Wisconsin Perinatal Region.

Some characteristics of the twin population delivered the past four years at our Perinatal Center are shown in Table 1. The incidence of twin deliveries in most US hospitals is 1.1%, slightly lower than our experience (1.4%) probably due to referral patterns of the region. The gestational ages of twin births are shifted towards prematurity; 24% were born at ≤ 33 weeks—in comparison to < 4% of singleton births at Madison General Hospital. The rate of cesarean section over the four years averaged 29%. This also was higher than our hospital overall rate of 12-18% for that period. The rate of low APGAR scores (0-3) at one minute in vaginal deliveries in our hospital is 3.8%. Note that the incidence of low APGAR scores was higher in Twin A (11%) and even higher (21%) in Twin B. Thus, there is significant perinatal asphyxia occurring, even though resuscitation efforts have corrected the differences between twins by five minutes. Hypoglycemia and Small for Gestational Age (SGA) infants were found in about 10% of the twin

Table I—Twin Births—1976-1979
Madison General Hospital

Total twin deliveries		124 (1.4% of all deliveries)	
Gestational age	≤37 wk	50%	
	≤33 wk	24%	
Cesarean section rate		29%	
APGAR (0-3)	*Twin A*	%	*Twin B*
1 min	11		21
5 min	6		5
Common neonatal problems:			%
Hypoglycemia Dextrostix® < 30 mg % < 3 hr			10
Small for Gestational Age (< 10th percentile)			9.4
Respiratory Distress Syndrome (RDS) 16/124			
Both	7		
One twin	9		
Still births	10		
Neonatal deaths	21		
Immaturity (< 750 gm)		9	
RDS and prematurity		11	
Necrotizing enterocolitis		1	

From the Department of Pediatrics, University of Wisconsin and the Wisconsin Perinatal Center, Madison General Hospital, Madison, Wisconsin. Publication support provided. Reprint requests to: Richard D Zachman, PhD, MD, Wisconsin Perinatal Center, 202 South Park St, Madison, Wis 53715 (phone: 608/267-6099). Copyright 1980 by the State Medical Society of Wisconsin.

births. There appeared to be only one significant twin-to-twin transfusion resulting in one infant requiring plasmaphoresis because of symptoms associated with a central hematocrit above 65%.

With the high incidence of premature deliveries in the twin delivery population, Respiratory Distress Syndrome (RDS) occurring in 16 sets of the 124 twins is to be expected. There have been several reports in the past speculating why only one of a twin pair might have RDS. A higher incidence of RDS in the second born (and possibly the more asphyxiated) has been noted. Another theory is that the male is more apt to get RDS than the female. In our own group, seven of nine of those with RDS were males, and six of nine were second born and had one minute APGAR score of $\leq$ 6. Of equal interest, and possibly more important, is that all those cases with RDS had immature L/S ratio values on their gastric aspirates. Similar findings have been reported in four other twin cases in whom L/S values were determined on their tracheal washes.[5]

There were 10 stillbirths and 21 neonatal deaths in the 248 births of these 124 twin pregnancies. Immaturity (< 750 gm and < 26 wks gestation) accounted for 43% of those deaths; and prematurity with RDS accounted for 48%.

The apparent solution to lower the high perinatal mortality rate in twin births is to prevent the high incidence of early deliveries and associated RDS. Bed rest has been suggested to add weight and improve twin perinatal outcome rates. A recent review on the topic, however, points out that the approach is far from standard and works only in certain pregnancies.[6] Methods for prevention and treating premature labor must be utilized effectively in twin pregnancies. In the four years reported here isoxsuprine (Vasodilan®) was ineffective in stopping labor for three days 50% of the time. Recent use of terbutaline or ritodrine might be more effective in the future and is being studied. Though the efficacy and safety is still doubtful in some person's minds, consideration of antenatal steroids in preterm twin pregnancies also should be considered.

Obviously twin pregnancies are still a significant perinatal problem and offer a challenge to perinatal care in 1980.

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Abstracts

Evaluation of the antibacterial efficacy of four agents for handwashing

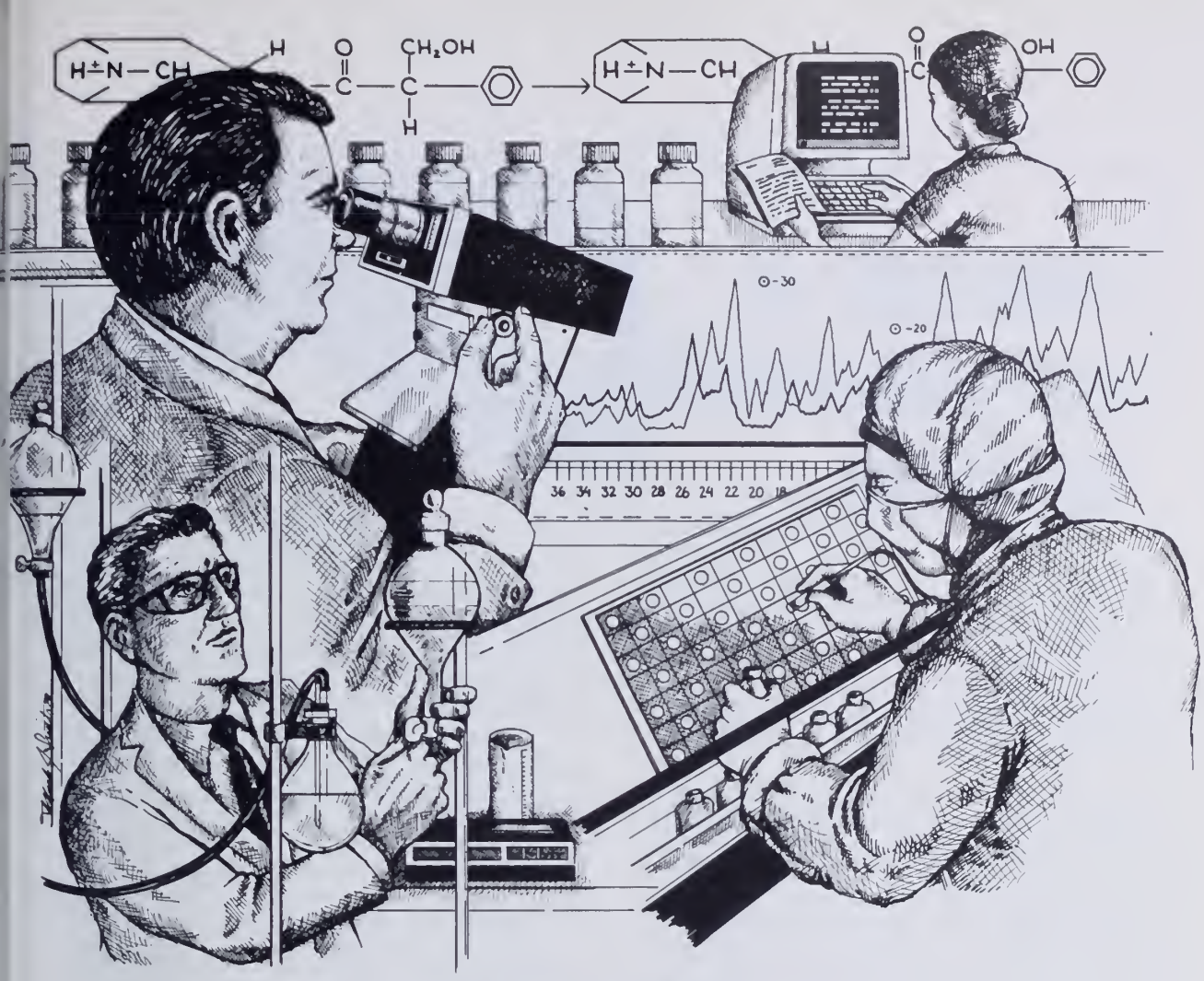
DENNIS G MAKI, MD; MARY ANN ZILZ, RN; and CARLA J ALVARADO, BS (University of Wisconsin Hospitals, and Center for Health Sciences, Madison, Wis)

Reprinted from Current Chemotherapy and Infectious Disease Proceedings of the 11th ICC and the 19th ICAAC, *Am Soc Microbiol*, 1980

Pathogenic organisms carried on the hands of medical personnel comprise one of the most important reservoirs and modes of spread of infection in the hospital. Handwashing before and after patient contacts is regarded axiomatically as the most basic nosocomial infection control measure, its purpose being to reduce the number of potentially transmissible microorganisms comprising the transient hand flora.

This study confirmed laboratory studies in volunteers showing that the 4% chlorhexidine-containing solution now approved for use in the United States is superior to a nonmedicated soap and to an iodophor in reducing transient hand contaminants when used in a brief single handwashing of the type considered acceptable on patient-care units. It also reaffirms that a brief 15-s handwashing with nonmedicated soap or an iodophor results in little removal of the transient flora; the 4% chlorhexidine solution, however, produces a 1-log (or 90%) reduction in the transient flora even with a single brief handwashing. Their study further suggested that the 4% chlorhexidine solution provides persistent antibacterial activity between brief handwashings when used routinely on a patient-care unit, whereas periodic application of an alcohol foam or use of an iodophor detergent was no more effective in this regard than use of a nonmedicated soap. Chlorhexidine gluconate 4%* warrants consideration as a first-line agent for handwashing in high-risk areas of the hospital.

* Hibiclens®, Stuart Pharmaceuticals ■



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Cancer Column

Prepared and supported by the Wisconsin Clinical Cancer Center
in collaboration with the State Medical Society of Wisconsin

Interferon studies at the Wisconsin Clinical Cancer Center

INTERFERONS are body proteins with potent immunomodulatory and cellular effects. Animal work and preliminary clinical results suggest they may be useful in the treatment of human neoplasia. In 1978 the American Cancer Society (ACS) obtained $2 million of leukocyte interferon from the Finnish National Red Cross. The primary objective of planned studies was to confirm or refute activity of leukocyte interferon in neoplasia. A secondary objective was to better define the mechanism of action of interferons in man. Ten different American medical institutions were given enough interferon to study a total of 100 to 150 patients with nonHodgkin's lymphomas, multiple myeloma, melanoma, and breast cancer.

Dr Ernest Borden, Wisconsin Clinical Cancer Center, is the national study coordinator for the ACS interferon trial in recurrent breast cancer. The preliminary results from the four participating institutions, Wisconsin Clinical Cancer Center, M D Anderson Hospital, Roswell-Park Memorial Institute, Mt Sinai Medical Center, New York City, were reported at the annual meeting of the American Association of Cancer Research in San Diego in May. Of 23 patients treated for limited periods with interferon, five had partial responses. The duration of the responses ranged from 14 to 121 days. Two additional patients had reduction in measurable tumor although not sufficient to meet partial response criteria. Interferon was generally well tolerated, although significant weakness and anorexia complicated therapy of some patients. Temperature elevations to 102 F early in therapy courses were not a clinical problem. Reversible leukopenia was commonly encountered. Further ACS-sponsored clinical trials in recurrent breast carcinoma are planned to define the most effective dose and schedule.

Another clinical trial, currently active at the Wisconsin Clinical Cancer Center, is evaluating intra-arterial, intratumor interferon infusion in recurrent breast carcinoma, melanoma, and colorectal carcinoma. Although it is too early to report results, no major toxicities have occurred from intravenous and intra-arterial administration.

In addition to attempting to define clinical activity of interferons in neoplasia, studies are also underway at the Wisconsin Clinical Cancer Center to elucidate the mechanism of action of interferons. Enhancement of lymphocyte cytotoxicity for tumor cells by interferons has been demonstrated. In addition to augmentation of immunologic activity, interferons also directly inhibit tumor cell proliferation. Collaborating with Doctor Borden on the interferon studies have been Doctors Tom Hogan, Bruce Edwards, Alex Chang, and Mike Hawkins. Other studies at the University of Wisconsin, conducted by Dr Andrew Ball in the Department of Biophysics, are aimed at defining the biochemical mechanisms of interferons' actions. Doctor Ball has identified and purified specific enzymes in cells which result from interferons. These enzymes may be key to interferons' clinical effects.

Doctor Borden feels that it is important that interferons be placed in appropriate clinical perspective. Interferons have received publicity out of proportion to what is known of their clinical effectiveness. They seem to have activity in breast carcinoma, lymphomas, and multiple myeloma. However, there is no evidence as yet that interferons are curative for any neoplasms. Because of limitations in interferons' supplies, the emphasis at present will remain on research evaluations in defined sensitive tumors. These trials should allow definition of maximum dose and optimal treatment schedules. Clinical studies with these objectives are continuing at the Wisconsin Clinical Cancer Center.

—Dorothy J Buchanan-Davidson, PhD
Science Writer, WCCC ■

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or the State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

Organizational SMS

SMS Leadership Conference set for November 14

County, state, and specialty society officers will have an opportunity to exchange views at an all-day Leadership Conference to be held Friday, November 14, at the Medical College of Wisconsin Alumni Education Center in Milwaukee. The State Medical Society is sponsoring the conference which will be followed by the SMS Council meeting on Saturday, November 15, at the Brookfield Marriott, in suburban Milwaukee. SMS members may attend Council meetings; however, they are asked to notify the Secretary's office in advance so that space accommodations can be arranged. ■

New Zealand-Australia tour

November 5 is the departure date for an exciting tour to New Zealand and Australia under sponsorship of the State Medical Society for its members. The tour will take physicians and their spouses through some of the most beautiful and varied scenery in the world—from the 12,000-foot Mount Cook and the fiords of New Zealand, to the magnificent harbor and beaches of Sydney and the sunbaked Australian outback. Of particular interest will be a visit to the airbase of the famous Flying Doctors Service which provides physician services to much of the sparsely settled Australian hinterland. A tour brochure and other details were mailed to all SMS members. Further information may be obtained upon request to Peter Wood of SMS Services, Inc: Madison area phone 257-6781 or toll-free in Wisconsin 1-800-362-9080. ■

Membership classifications for young physicians

Many young physicians are eligible for a special membership classification at the State Medical Society which carries with it a reduction in membership dues.

Any physician who has been a member of a state medical society for the preceding 12 months and is elected to membership in this society within six months of completing residency, fellowship, or fulfillment of government obligation enjoys a dues reduction of 50 percent for the first year and 25 percent the second year.

This society and most other state medical societies have a special membership classification for Residents which has a very low dues structure.

The AMA, to attract new members, has a new physician membership classification. Under this membership classification a new physician in his first full year of practice is eligible for a 50 percent reduction in AMA dues for one year.

Physicians are urged to seriously consider joining organized medicine as early as possible to take advantage of these special membership rates. ■

Attention physicians: Reduced practice membership classifications

The Society reminds physicians who have reached age 65 and practice 1,000 hours or less during the calendar year, but do not qualify for associate membership, may apply for a "senior" membership which waives 50 percent of the regular membership dues.

This special membership classification must be applied for through the physician's county or state society. The change will become effective January 1 following receipt of the request.

In addition, the Society reminds physicians who are over 70 years old that they are not required to pay AMA dues as long as they are members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

The dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues-exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification (less than 240 hours of practice per year) which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classifications can be arranged. ■

Medicaid update

The Society's Physicians Alliance commissioners and staff are maintaining extremely close contact with the day-to-day developments concerning the Governor-ordered 4.4% budget cut as it impacts on the Medicaid program. Check the NEWS YOU CAN USE section of this issue for further details. ■

1980 Membership up

At July 31 the number of SMS physician members is 51 ahead of the same time a year ago. Congratulations to the following county medical societies for having 100% of their members' dues paid in full for 1980:

Calumet, Clark, Fond du Lac, Forest, Green Lake-Waushara, Iowa, Jefferson, Langlade, Lincoln, Oconto, Racine, Rusk, Sawyer, Sheboygan, Vernon.

At September 1, 4570 members had paid 1980 dues in full. While that news is encouraging, there are still 251 members who have part or all of their 1980 dues outstanding.

Those members not having paid any 1980 dues by October 15 will be removed from the roster. ■

SMS annuity unit value: $3.42

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $3.42 as of July 31, 1980. This compares with $3.17 as of June 30, 1980 and $3.08 at May 30, 1980. ■

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of August 4, 1980

NEW MEMBERS

COUNTY MEDICAL SOCIETY

DANE

Behling, Ronald E, 4210 Beverly Rd, Madison 53711 (1950, Resident, Anesthesiology)

Dineen, Mary Kay, 1313 Fish Hatchery Rd, Madison 53715 (1948, Regular, Obstetrics and Gynecology)

Hirsch, Thomas J, 1313 Fish Hatchery Rd, Madison 53715 (1949, Regular, Internal Medicine/Rheumatology, Certified-IM)

Manalo, Felipe B, 1 South Park St, Madison 53715 (1937, Regular, Internal Medicine/Oncology, Certified-IM)

GREEN

Wisnefske, David D, Legler Rd, Rte 4, Box 44, Brooklyn 53521 (1949, Regular, Radiology, Certified)

MILWAUKEE

Yamat, Jaime B, 8825 Greenmeadow Lane, Greendale 53129 (1939, Regular, Anesthesiology)

PIERCE-ST CROIX

Evans, Michael R, 409 Spruce St, River Falls 54022 (1945, Regular, General Surgery, Certified)

RICHLAND

Smith, Robert P, 1313 W Seminary St, Richland Center 53581 (1953, Regular, Family Physician)

SHAWANO

Carlson, William J, 117 E Green Bay St, Shawano 54166 (1950, Regular, Family Physician)

WOOD

Baxter, Joseph W Jr, 1000 North Oak Ave, Marshfield 54449 (1946, Regular, Diagnostic Radiology)

Clasen, Richard W, 315 First St, Nekoosa 54457 (1948, Regular, Internal Medicine, Certified)

Kimmel, Roger L, 1000 North Oak Ave, Marshfield 54449 (1943, Regular, Diagnostic Radiology)

continued►

CES FOUNDATION

CONTRIBUTIONS—JULY 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1980.

Unrestricted

Richard D Adelman, MD; SMS Members; WISPAC; LaCrosse County Medical Society Auxiliary; Trempeauleau-Jackson-Buffalo County Medical Society Auxiliary; Marathon County Medical Society Auxiliary; Sheboygan County Medical Society Auxiliary—*Voluntary Contributions*

Restricted

Membership Donations—*Aesculapian Society*

RA Dart, MD—*Endowment Fund*

W Bruce Fye, MD—*Sale of Medical Books (Endowment Fund)*

Wyeth Laboratories; Wisconsin Rural Rehabilitation Corp—*Medical Student Summer Externship Program*

Meyer Brothers-Dave Meyer—*Museum of Medical Progress*

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State Medical Society—*Rex E Graber, MD; Elmer B O'Leary, MD; Alejandro R Guansing, MD; Saul I Waxman, MD* ■

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Godfrey, Charles B, Madison, to 6015 Sarita St, La Mesa, CA 92041
Goodman, George B, Middleton, to 45 Brittany Court, Charlotte, NC 28211
Holt, Robert E, Madison, to 9455 Watertown Plank Rd, Milwaukee 53226
Kurtz, Jeffrey A, Middleton, to 1010 Bird St, Wausau 54401
Stainer, Gregory A, Madison, to 4951 Arroyo Lindo, San Diego, CA 92117
Wester, Susan M, Madison, to 229½ Eighth Ave, SE, Rochester, MN 55901
Wixson, Richard C, Madison, to 739 Little Sister Rd, Rte 1, Box 92C, Sister Bay 53234

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Cameron, William G, North Fort Myers, FL, to 5575 N Shore Dr, Eau Claire 54701

JEFFERSON

Netzow, Earl J, Johns Island, SC, to Rte 1, Box 51F, Cedar Grove 53013

LACROSSE

Counihan, Colleen M, LaCrosse, to 1001 E Henry Clay St, Whitefish Bay 53217
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Jiroch, John T, Manitowoc, to 2807 S Superior St, Milwaukee 53207
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MARATHON

Comstock, Michael K, Rothschild, to 4200 Patricia Dr, Urbandale, IA 50322
Thorpe, Ray M, Wausau, to 190 E Bannock St, Boise, ID 83702

MILWAUKEE

Levin, Barry K, Milwaukee, to 2600 Willow Glen Rd, Pikesville, MD 21209
Linde, John W, New Berlin, to 1805 Grant Circle, Rola, MO 65401
Mirhoseini, Mahmood, Milwaukee, to 302 Grand Ave, Wausau 54401
Sargent, James W, Milwaukee, to VA Hospital, Iron Mountain, MI 49801
Smith, Miles B, Milwaukee, to VA Medical Center, Wallawalla, WA 99362
Woods, R John, Milwaukee, to 66 Pageant St, Belen, NM 87002

OCONTO

Glazier, Edward H, Oconto Falls, to PO Box 144, Waupaca 54981

OUTAGAMIE

Tatlock, Thomas W, Kansas City, MO, to 610 E Longview Dr, Appleton 54911

PORTAGE

Barkow, Kathleen M, Stevens Point, to 1181 Porlier St, Green Bay 54301

RACINE

Bacon, Glenn A, Temple, TX, to 807 16th St, Racine 53403

RICHLAND

Edmondson, M Bruce, Richland Center, to 600 Highland Ave, Madison 53792

ROCK

Farnsworth, Richard W, Pompano Beach, FL, to 1324 E Racine St, Janesville 53545
Levin, Harlan M, Venice, FL, to 94 South Harmony Dr, Janesville 53545

TREMPEALEAU-JACKSON-BUFFALO

Schaefer, Steven E, Black River Falls, to 11410 Lorena Lane, El Cajon, CA 92020

WINNEBAGO

Ilvedson, Ronald E, Oshkosh, to 3004 Northwood St, Ames, IA 50010

WAUKESHA

Lofland, Leo J, Waukesha, to Rte 2, Box 257, Stetsonville 54480

WOOD

Billings, Kenneth J, Marshfield, to 1370 Baker St, Baker, OR 97814
Blaha, J David, Marshfield, to W Va University Medical Center, Morgantown, WV 26505
Gildersleeve, John W, Marshfield, to 407 E Third St, Duluth, MN 55805
Kayali, Bashar F, Marshfield, to 3901 Beaubien Blvd, Detroit, MI 48201
Martinson, Terry L, Marshfield, to 1301 Oriole Dr, Albert Lee, MN 56007
Sagert, Louis A, Marshfield, to 497 Curfew St, St Paul, MN 55104
Sampson, Charles E Jr, Marshfield, to 2500 N State St, Jackson, MS 39216

COUNTY-TO-COUNTY TRANSFER

Douglas to Milwaukee: Rosin, Louis R, 2315 North Lake Dr, Milwaukee 53211
Milwaukee to Dane: DeCock, David G, 1313 Fish Hatchery Rd, Madison 53715
Milwaukee to Ozaukee: Wall, Thomas, 326 West Pierre Lane, Port Washington 53074
Waupaca to Milwaukee: Biek, Richard W, 841 North Broadway, Milwaukee 53202 ■

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County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

"Physician coordinated" TV programs initiated

The first in a series of "physician coordinated" television programs was initiated in July in the Green Bay (Fox Valley) television area. The program is a weekly 30-minute broadcast viewed at 11:30 am Fridays on WLUK-TV (Channel 11) Green Bay. It features a live telephone call-in format and is hosted by an area Medical Society physician.

The program is a cooperative effort of the television station with the Public Affairs Committee of the Brown County Medical Society and the State Medical Society of Wisconsin. "The effort is an attempt to present responsible medically-oriented programming to the general public," according to John Guthrie, MD,* Brown CMS Public Affairs chairman.

A statewide effort also is underway to develop medically related television broadcasts in various TV markets. "Through this effort it is hoped that better communication between the physician and the general public will result," said Mike Brozek of the State Medical Society staff. Also underway is an effort to increase physician access to local health-related radio broadcasts as well as local newspaper contacts.

DANE: Two new awards recently were established by the Dane County Medical Society. The newly established Presidential Award will be presented to C Robert Jackson, MD* and Fred C Kriss, MD* of Madison, at the function of the Society and Auxiliary on October 18. The Presidential Award is bestowed upon Dane County Medical Society members who have provided exceptional service to the Society. Doctors Jackson and Kriss will be recognized because of their long, faithful, and effective service in the Society's legislative activities. The other award is the Board of Trustees Award and may be presented to any physician or other person involved in the healthcare field. Recipients of this award need not be a member of the Dane County Medical Society. The criteria for receiving this award is based upon conspicuous service by the healthcare provider to the community. Generally speaking, the recipients of this award "shall be noted and deemed to have provided exceptional service to the citizens of Dane County." Recipients of this award to be given also on October 18 are Joseph M Benforado, MD and Ms Dorothy Houden, RN, for their work and special contribution toward the care of alcoholics in Dane County.

MARATHON: Rheumatoid arthritis and stress related illnesses were the topics covered at a Family Practice Seminar recently held in Wausau. The Seminar was sponsored by the Marathon County Medical Society. Guest speakers included MDs William Kelley, professor and chairman of the Department of Medicine, University of Michigan, Ann Arbor; James Jefferson, associate professor of psychiatry, University of Wisconsin Medical School, Madison; and Thomas Ferris, professor and chairman of the Department of Medicine, University of Minnesota.

POLK: Dr Bud Norstrum of the St Louis Park (Minnesota) Medical Center spoke to the fourteen members of the Polk County Medical Society at its meeting July 17 in Balsam Lake. His subject was "Treatment of Coronary Heart Disease." Also on the program were Dr Paul Haskins* of River Falls, past chairman of the SMS Council, who explained events taking place in Madison, and Paul Jacobsen and Mike Brozek of the SMS staff. Discussions also were held concerning the public health nursing service, the initiation of a jail health service in Polk County in cooperation with the county sheriff, immunizations, family planning, and referral for hypertension and glaucoma screening. ■

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Donald J De Bruyn, MD, recently became associated with the Manitowoc Clinic. He graduated from the University of Michigan Medical School and served his internship and residency in internal medicine at the University of Michigan affiliated hospitals. He served as senior resident at the hospitals.

William Piotrowski, MD and **Alan Taber, MD,** have joined the medical staff of the Berlin Physician Clinic. They are associated with MDs Michael Tieman* and Richard Gubitz. Doctor Piotrowski graduated from Creighton Medical School in Omaha, Neb, and completed his internship and residency at Creighton Affiliated Hospital. Doctor Taber graduated from Northwestern University Medical School, Chicago, and finished his internship at Grant Hospital, Chicago, and his residency at St John's Hospital at the University of Minnesota.

Charles McCauley, MD, formerly of Cleveland, Ohio, has joined the Medical Center of Monroe in the Department of Internal Medicine. He graduated from the University of Illinois Medical School, Chicago, and served his residency in Akron, Ohio. He also completed a cardiology fellowship in Cleveland.

Richard A Reinhart, MD and **Patrick M Maloney, MD,** cardiologists, recently became associated with the Marshfield Clinic. Doctor Reinhart graduated from Kent State University College of Medicine, Columbus, Ohio. He completed his internship and residency in internal medicine, with the subspecialty of cardiology, at Duke University Medical Center, Durham, NC. Doctor Maloney graduated from the University of Washington Medical School, Seattle, and served his internship and residency at Case Western Reserve University, Cleveland, Ohio.

Charles L Woodhouse, MD, Eau Claire, has joined the Midelfort Clinic medical staff in the Department of Internal Medicine. Doctor Woodhouse graduated from the University of Kansas School of Medicine and completed an internship in anatomic pathology at St Francis Hospital, Wichita, Kans. An internship in internal medicine was completed at the University of Kansas School of Medicine and a fellowship in medical oncology was completed at the University of Wisconsin Medical School, Madison.

Anatol Stankevych, MD, Green Bay recently joined the Eye and Ear Associates in Green Bay. Doctor Stankevych graduated from the University of Illinois School of Medicine in 1976 and served his internship and a residency in ophthalmology at Cook County Hospital, Chicago. He is a member of the American Ophthalmology Society and American Contemporary Ophthalmology Society.

Robert J Holly Sr, MD, has joined MDs Richard C Wolfgram,* James R Plos,* and Richard C Murray,* in the practice of obstetrics and gynecology in Oshkosh. Doctor Holly graduated from the Medical College of Wisconsin, Milwaukee, and completed his residency at St Joseph Hospital in Milwaukee.

Jacob George, MD, an orthopedic surgeon from Kerala, India, recently became associated with The Monroe Clinic in Monroe. Doctor George graduated from Seth G S Medical College and King Edward VII Memorial Hospital, affiliated with the University of Bombay. He interned at Somerset Hospital in New Jersey, and his residency was completed at the State University of New York, Stony Brook.

Young So Kim, MD and **Robert G Shurtleff, MD,** recently joined the Gundersen Clinic in LaCrosse. Doctor Kim, a radiologist, served an internship at Pittsburgh's St Francis General Hospital and a radiology residency at Washington County Hospital, Hagerstown, Md. He also served diagnostic radiology residencies at Methodist Hospital, Indianapolis, and a neuroradiology residency at Strong Memorial Hospital in Rochester, NY. Doctor Shurtleff graduated from the University of Illinois Medical School, Chicago, and served his internship and residency in anesthesiology at Northwestern Memorial Hospital, Chicago. Prior to coming to LaCrosse, Doctor Shurtleff had a fellowship in pediatric anesthesia at Children's Memorial Hospital in Chicago.

Jay DeVore, MD, Janesville, recently was appointed chief of the Department of Anesthesiology at Mercy Hospital in Janesville. Doctor DeVore has served on the faculty at the University of California at Irvine where he practiced academic medicine for the past 10 years. He graduated from the University of Chicago Medical School and interned at Northwestern Memorial Hospital in Chicago. His residency was served at the U S Naval Hospital in Philadelphia. He also completed a fellowship at Columbia Presbyterian Hospital in New York.

Richard Haas, MD, Sheboygan, recently became associated with Marvin G Jumes, MD,* at Sheboygan Memorial Hospital in the practice of anesthesiology. Doctor Haas graduated from Queen's University, Kingston, Ontario. Prior to his anesthesiology residency at the Medical College of Wisconsin, he was a research fellow with the Ontario Heart Foundation.

Randy Theller, MD, recently opened his medical practice in Chilton. He graduated from the University of Wisconsin Medical School, Madison, and served his family practice residency at Waukesha Memorial Hospital.

James C Pollock, MD, recently joined the medical staff of The Monroe Clinic. Doctor Pollock, a specialist in gastroenterology, graduated from the University of Illinois Medical School and served his residency at Northwestern University in Chicago, where he also completed a two-year fellowship in gastroenterology.

Henry S Schutta, MD, recently was named chairman of the Department of Neurology at the University of Wisconsin Medical School, Madison. He succeeds Raymond Chun, MD* who was acting chairman and will return to teaching and research. Doctor Schutta graduated from the Sidney Australia School of Medicine and served residencies in London and Sidney, and a fellowship in neuropathology at Pennsylvania Hospital in Philadelphia. Most recently, he was a professor of neurology at the State University of New York, Downstate Medical Center, Brooklyn.

Harold Anschuetz, MD, Fort Atkinson, recently became associated with MDs James C H Russell,* Henry Aufderhaar,* and Frank Beran.* Doctor Anschuetz graduated from the Medical College of Wisconsin, Milwaukee, and completed his family practice residency at Deaconess Hospital in Milwaukee.

Stephen M Devine, MD, LaCrosse, recently became associated with the Gundersen Clinic medical staff in the Department of Internal Medicine. Doctor Devine graduated from St Louis University Medical School and served his residency at LaCrosse Lutheran Hospital. He also had a fellowship in cardiology at Penn State University prior to joining the Clinic.

Keith Flachsbart, MD, Marshfield, recently joined the Marshfield Clinic. A cardiovascular and thoracic surgeon, Doctor Flachsbart graduated from the University of Nebraska College of Medicine in Omaha. His internship was served at Chicago's Rush-Presbyterian-St Luke's Hospital and by a two-year service tour with the United States Navy. Doctor Flachsbart completed his residency in cardiovascular and thoracic surgery at the Hospital of the Good Samaritan and Children's Hospital in Los Angeles.

Stephen B Webster, MD,* LaCrosse, recently was named "Teacher of the Year" by the graduating resident house staff at the Gundersen Clinic. Doctor Webster, a dermatologist, has been a member of the clinic medical staff since 1971.

Les P Harrison, MD, Steve Q Paulson, MD and **Mark Hansen, MD,** recently became associated with the medical staff of St Joseph's Hospital, Chippewa Falls. Doctors Harrison and Paulson graduated from the University of North Dakota Medical School and completed their internal medicine residencies at the University of North Dakota Affiliated Hospital in Fargo. Doctor Hansen graduated from the University of Minnesota Medical School and completed his residency in pediatrics at Milwaukee Children's Hospital.

William L Washington, MD, has joined the medical staff of the Marshfield Clinic. A specialist in rheumatology, Doctor Washington graduated from the University of Missouri School of Medicine in Columbia and completed his internship at the Los Angeles

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County University of Southern California Medical Center, and at the University of California-Irvine Affiliated Hospitals. He served two years in the United States Navy at Camp Pendleton, Calif, and then returned to the University of California-Irvine to complete his residency.

Donald Caine, MD,* Fox Point, recently was honored by the board of directors of the Medical-Surgical Clinic for his 25 years of service. Doctor Caine is medical director of the Clinic. A member of the medical staffs of St Luke's and Deaconess hospitals, as well as Mt Sinai Medical Center, Doctor Caine joined the Clinic in 1955.

John Renner, MD,* Madison, recently resigned from the University of Wisconsin Medical School to direct a National Family Practice Research Center in Kansas City, Mo. Doctor Renner founded the UW's Medical School Department of Family Medicine and Practice and was chairman of the department. In Kansas City, Doctor Renner will develop a small family practice residency program for St Mary's Hospital and will direct a new National Family Practice Research and Development Center.

Peri L Aldrich, MD,* recently joined the medical staff of the Tri-county Medical Clinic in Pulaski. Doctor Aldrich graduated from Brown University Medical School in Providence, RI, and completed her family practice residency at Wasukesha Memorial Hospital.

William Hopkins, MD, recently began his medical practice at the Owen-Withee Family Clinic in Owen. Doctor Hopkins graduated from the George Washington University Medical School in Washington, DC, and completed his family practice residency at the University of Minnesota Hospitals.

Denis J Pleviak, MD, New Holstein, recently opened his medical practice in association with Francis P Larme, MD.* Doctor Pleviak graduated from the University of Illinois Medical School and served his family practice residency at MacNeal Memorial Hospital in Berwyn, Ill. ■

NEWS YOU CAN USE

continued from page 58

These options will be finalized this month and presented to the Physicians Alliance Commission on September 26 and the SMS Council on September 27. More information will be provided in future issues of the WMJ and MEDIGRAM.

In a related development, DHSS Secretary Percy accepted a proposal from the major provider groups (including SMS) that he develop an ad hoc advisory committee on T-19 utilization and benefits to assist the Department in its 1981-1983 budget preparation. SMS was represented at the first meeting of that committee on August 26. During the coming weeks, the Society and other provider groups will be preparing formal recommendations to the Department regarding changes in the Medicaid program for the 1981-1983 biennium. The next meeting was scheduled for September 10 with final recommendations expected to be completed in October. ■

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Deaconess Hospital, Milwaukee, recently announced the appointments of William C Van Clief, Whitefish Bay, and Gregory T Burns, West Bend, to its administrative staff. Mr Van Clief, formerly controller at St Francis Hospital, Milwaukee, was named director of fiscal services. He supervises accounting, budgeting, billing, and collection operations at the 300-bed facility. He received his master's degree from the University of South Florida, Tampa. As assistant administrator, Mr Burns is responsible for operations of the hospital's satellite clinics program and the medical-surgical and tumor clinics. He also oversees the Family Practice, EKG, Physical Therapy, and Housekeeping Departments. Mr Burns earned his master's degree in health services administration from the University of Wisconsin-Madison, and served his administrative residency at Waukesha Memorial Hospital.

St Luke's Hospital, Racine, recently announced the election of officers to its medical staff. William J Smollen, MD,* has been elected president; Howard I Gass, MD,* vice-president; Henry J Barina, MD,* secretary, and Ernest L MacVicar, MD,* treasurer. All of the physicians are from Racine.

William E Johnson Jr, president of Methodist Hospital in Madison, was elected to the Board of Governors of the American College of Hospital Administrators. The election took place July 28 during the AHA/CHA Annual Convention in Montreal. In his new position Mr Johnson will represent the College and its affiliates of the society's District IV, encompassing Illinois, Indiana, Wisconsin, and Michigan. His term is for four years. The ACHA also has announced its roster of new nominees. From Wisconsin these include: Dennis L Heyde, director of finance, St Joseph's Hospital, Chippewa Falls; James R Larsen, vice president of finance, Kenosha Memorial Hospital, Kenosha; and Jeffrey L Martin, assistant administrator, Berlin Memorial Hospital, Berlin.

The University of Wisconsin Medical School, Madison, recently announced the appointment of Donald R Harkness, MD as chairman of the Department of Medicine. He will replace David T Graham, MD* who plans to return to research, teaching, and clinical practice in the department. Doctor Harkness, who will take the position on October 1, was formerly a University of Miami hematology professor and chief of the Division of Hematology. As the recipient of two fellowships, Doctor Harkness was a research associate at both the National Institutes of Arthritis and Metabolic Diseases and at the National Heart Institute. In addition, he was a postdoctoral fellow at the American Cancer Society, Inc, from 1963-1964 and held a special research fellowship with the U S Public Health Service from 1964-1965. He was a John and Mary Markle Scholar in Academic Medicine from 1966-1971. He is a graduate of the Washington University School of Medicine in St Louis, Mo. ■

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

In G.I. therapy

Adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship [illegible] established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide is used alone, drowsiness, ataxia, confusion occur, especially in elderly and debilitated, [illegible] able in most cases by proper dosage adjustment but also occasionally observed at lower dosage ranges. Syncope reported in a few instances; encountered: isolated instances of skin eruption, edema, minor menstrual irregularities, nausea, constipation, extrapyramidal symptoms, [illegible] and decreased libido—all infrequent, generally controlled with dosage reduction, changes in patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products, Inc
Manati, Puerto Rico 00701

WPS

report

for Wisconsin Physicians

Volume IX, Number 5

September, 1980

Notification of Physician's Status

WPS identifies physicians for fee-for-service claim payments on the basis of the physician's five-digit "provider number" assigned by WPS. If the physician's five-digit number is incorrect or missing from the claim form submitted, reimbursement may not be made directly to the physician or clinic. Therefore, the correct five-digit provider number should always be included on the form.

Because WPS attempts to reimburse the physician directly whenever possible, it is very important that WPS be notified **in writing** of any change in a physician's status--whether he or she joins, leaves, or retires from a practice. Lack of prompt notification may result in payments being unnecessarily delayed or sent to an incorrect location.

If a physician begins practice in Wisconsin and wishes to obtain a WPS provider number, he or she must supply the following information:

1. Name
2. Address
3. Wisconsin Medical License Number
4. Speciality
5. Is the physician board certified or eligible?
6. Social Security Number
7. Is this the physician's first practice, or, if not, where has the physician practiced before and with whom (group, clinic, partnership)?
8. Status of outstanding accounts and whether accounts are associated with a clinic, group, or partnership.
9. Tax Identification Number if in a corporation
0. Authorization to Pay Agreement must be signed by each physician if payment is to be made to a clinic, group, or partnership (including Service Corporation). Forms are available upon request (see address below).

This information must also be supplied if the physician joins an existing clinic, physician group or partnership. A WPS provider number is necessary whenever service to WPS policyholders and WPS-administered Medicare Part B beneficiaries is provided in order for direct reimbursement to be made.

The request for a provider number must be **in writing** and should be mailed to:

Central Provider Control
P.O. Box 1787
Madison, Wisconsin 53701
Attention. Mrs. Johnson, CPCU

If the request is sent to any other post office box, processing may be delayed significantly.

Also, the written request should clearly indicate the physician's current mailing address. The request should be sent separately on office letterhead, and **not** as part of a claim or other correspondence.

If the physician does not receive a provider number within ten (10) working days from the date of mailing, Mrs. Johnson should be contacted at (608) 221-4711 extension 420. Mrs. Johnson may also be called if any clarification is desired regarding the above information.

If a doctor leaves or retires from practice, Mrs. Johnson should be notified **in writing** at the above address. Also, the same procedure is used if a physician leaves the group or clinic. Finally, physicians should notify Central Provider Control **in writing** of any change in their specialty, certification status, or address.

WPS makes every effort to reimburse physicians directly for their services as promptly as possible, and following these procedures will enable this to be accomplished with maximum efficiency. Thank you, for helping us help you.

CONTRACT EXCLUSIONS

Excessive paperwork harms the efficiency of both your office and WPS. It is expensive for your office to process claim forms for services that are not benefits of regular WPS policies. The following is a description of the most common exclusions found in WPS health insurance contracts. With it, you can advise your office's patients whether or not they may expect insurance coverage and perhaps discourage the filing of unnecessary claim forms.

Remember that the following list contains standard exclusions on all WPS policies. Certain WPS policies may contain **other** exclusions not discussed here. If you need to know if a service is covered under a patient's specific WPS policy, obtain the patient's seven-digit subscriber number and contact WPS Inquiry Services (608-221-4711).

No WPS policy provides benefits for:

- Anything covered by Workers' Compensation or the United States Veterans Administration.
- Anything covered by other federal, state, or local government agencies unless the patient must pay for all or a portion of those services.
- Any services, supplies, or equipment provided before the date that WPS coverage goes into effect or before the completion of any applicable waiting period.
- Care of any condition caused by any type of military action, atomic, or thermonuclear explosion or radiation.
- Physical examinations designed to provide health information for a third party, such as for schools, employers, insurance companies, sports, marriage, or summer camps
- Laboratory and x-ray procedures associated with such physical examinations.
- Anything for purely beautifying or cosmetic purposes unless (under some contracts) necessitated by accident.
- The examination, treatment, or removal of corns, callousities, and similar foot conditions including trimming or partial removal of toenails.

The preceding list is another feature of the WPS effort to make claims filing procedures as simple and efficient as possible.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P O. Box 8190, Madison, Wisconsin 53708.

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

Anesthesiologist wanted to join the Central Wisconsin Anesthesiology, SC, which consists of three established, hospital-based anesthesiologists. All specialties are served including open heart, neuro, obstetrics & gynecology. If interested phone 715/845-5505 or write to: Central Wisconsin Anesthesiology, SC, 425 Pine Ridge Blvd, Suite 207, Wausau, Wis 54401. 7-9/80

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 20-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 7tfn/80

Internist wanted to practice in conjunction with a six-member Internal Medicine Department of a 20-physician multispecialty group, located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen L Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. Phone: 414/632-7521. 8tfn/80

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

General Internist: Join an 18-physician multispecialty clinic in Appleton, Wis. Have departments in pediatrics, surgery, family practice, internal medicine and OB/GYN. Need another internist. Excellent hospitals, guarantee and incentive compensation. Complete benefit package. Medium-size community with excellent educational, cultural, recreational, and shopping opportunities. Contact Art Schuetze, Medical Arts Clinic, SC, 401 North Oneida St, Appleton, Wis 54911. Phone: 414/739-0171. 9-11/80

Fifty-physician multispecialty clinic in West Central Wisconsin wants allergist, cardiologist (noninvasive), pediatrician, and family practitioner to do acute medicine. Also family practice openings in nearby satellite offices. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Admin, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5266. 9-12/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Southeastern Wisconsin. Expanding emergency service, St Mary's Medical Center, Racine, has openings for experienced emergency physicians. American graduates, HCLP, ACLS. Fee for service. Forty-hour week. Send curriculum vitae to Director, Emergency Services, St Mary's Medical Center, Racine, Wis 53405. Phone: 414-636-4011. 9-10/80

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Family practice. Younger family physician for association in practice. Individualized practices, and coverage reciprocity. Contemporary modern office. New 165-bed family practice hospital under construction. Write to: Physicians in Family Practice, 120 Siegler St, Green Bay, Wis 54303. 414/497-0707. 8-9/80

GP or FP wanted to take over my practice while on leave for two years. Well-equipped, 2-man medical facility, near 55-bed hospital, 80-bed nursing home attached. Trade area 15,000. Good schools, churches, rural, good hunting and fishing nearby. Reply with CV to Dept 479 in care of the Journal. 7-9/80

General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

OBSTETRICIANS-GYNECOLOGISTS WANTED

Obstetricians-Gynecologists board certified or eligible wanted to join in practice with obstetrician-gynecologist in a city of 100,000 on Lake Michigan between Milwaukee and Chicago. Excellent schools, medical school affiliation, security of freedom of practice in independent small group. Contact: Elizabeth A Steffen, MD, 734 Lake Ave, Racine, Wis 53404. Phone: 414/637-8311. 6tfn/80

Physicians Exchange

continued

Multispecialty Group of 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Ophthalmologist
- Psychiatrist
- Dermatologist
- Family Practitioner

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. No personal investment. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 4tfn/78

Internist—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

General surgeon wanted to join group of six family practice physicians in a rural community of northwestern Wisconsin. For additional information contact F H Goetsch, MD, Spooner, Wis 54801. Phone: 715/635-2151. 8-10/80

Rheumatologist wanted to join four orthopedic surgeons in a very desirable north central Wisconsin community with a drawing population of 70,000. Active practice assured, shared "on call" provided, research grants available. New Clinic facility located within new 35 million dollar hospital complex. Outstanding personal benefit programs, generous guaranteed income. For further information contact: Lloyd Engstrom at 715/842-3202, or write PO Box 1646, Wausau, Wis 54401. 8-12/80

Wisconsin, Oshkosh: Career Emergency Physician with residency training and/or experience as emergency physician. Well-established fee-for-service corporation. Active community hospital with brand new physical facilities. Excellent staff backup, paramedic program, telemetry, flexible scheduling, competitive salary. Fringes: funded CME, generous health and disability insurance allowance, corporate-paid retirement plan, one month vacation, paid malpractice. ACLS certification required. Send complete CV: T M Loescher, MD, 2520 Crestview Dr, Appleton, Wis 54911. 7-9/80

Locum Tenens work wanted. Family and general practice, open availability. T C Kolff, MD, 801/566-1666. 9-11/80

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN

MEDICAL PROFESSIONAL PLACEMENTS

5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency 9tfn/79

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Hematology/Oncology
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Indiana—Fort Wayne: Emergency physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc, 4400 Broadway, Suite 306, Kansas City, Missouri 64111, 816/931-3040. 7-9/80

Family Practice, Hales Corners, Wis—to join 3 physicians in established practice. Board eligible/certified family physician or general practitioner, OB experience preferred. Guaranteed salary, paid professional liability insurance, opportunity for future partnership. Send your curriculum vitae to Whitnall Family Practice, 6080 South 108 Street, Hales Corners, Wis 53130 or call 414/425-5566 p7-9/80

Racine Medical Clinic, SC, multispecialty group of 20 physicians has a practice association for:

- Family/General Practitioner
- General Surgeon
- Pediatrician

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 9tfn/80

Wanted. Board Certified or Eligible OB/GYN; immediate opening with 8 physicians; multispecialty group of 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon. Clinic building is next to community hospital; expanding service area in western Milwaukee metro fringe location; first-year salary with optional second-year corporate stockholder; excellent fringe benefits including pension and profit-sharing plans. Contact J L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone 414/673-5745 collect. 5tfn/80

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Board certified general surgeon desires to relocate in Wisconsin near large city. Wisconsin license. Willing to do some general practice. References upon request. Contact Dept 481 in care of the Journal. 7-11/80

Family Physician—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Medical Facilities

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For lease: Approximately 1500 sq ft, furnished or unfurnished, in West Milwaukee, edge of Wauwatosa. 9300 West Capitol Dr, Milwaukee. Perfect for Internist or Family Practitioner. Four exam rooms; consultation, lab, insurance, and waiting rooms. Favorable terms. For further information contact: Phone 414/463-6650. 9tfn/80

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BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

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Bookshelf

New books received *are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.*

Planet Medicine. By Richard Grossinger. Anchor Press/Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1980. Pp 336. Price: $5.95.

Leaving Home. By Jay Haley. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1980. Pp 280. Price: $16.95.

Current Pediatric Diagnosis and Treatment. 6th Edition. By C Henry Kempe; Henry K Silver; Donough O'Brien. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1980. Pp 1124. Price: $20.00.

General Ophthalmology. 9th Edition. By D Vaughan and T Asbury. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1980. Pp 410. Price: $15.00.

ABC of Medical Treatment. By D C Banks. Churchill Livingstone Inc, 19 West 44th St, New York, NY 10036. 1980. Pp 373. Price: $17.50.

Basic Biostatistics in Medicine and Epidemiology. By Alfred A Rimm, Arthur J Hartz, John H Kalbleisch, Alfred J Anderson, Raymond G Hoffmann. Appleton-Century-Crofts, 292 Madison Ave, New York, NY 10017. Pp 353. Price: $16.50.

Review of Medical Microbiology. By E Jawetz, J L Melnick, E A Adelberg. 14th edition. Lange Medical Publications, Los Altos, Calif 94022. 1980. Pp 591. Price: $14.00.

The Pilates Method of Physical and Mental Conditioning. By Philip Friedman and Gail Eisen. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1980. Pp 191. Price: $12.95. ■

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of poblication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1979 through Aug 31, 1980.

WISCONSIN—1980

OCTOBER 3, 1980: *Wisconsin Oncology Group Conference.* UW Clinical Science Center, Madison. Info: Paul Tracy, MD, 1900 University Ave, Madison 53706. Phone: 608/263-3455.

OCTOBER 4, 1980: *Fall Center Conference.* UW Clinical Science Center, Madison. Info: American Cancer Society/Wisconsin Division, 611 N Sherman Ave, Madison 53704. Phone: 608/249-0487.

OCTOBER 3-5: Midwest Allergy Forum, sponsored by Wisconsin Allergy Society. Hyatt Regency Hotel, Milwaukee. Info: Morton Soifer, MD, 707 W Glencoe Pl, Bayside, Wis 53217.

OCTOBER 6-10, 1980 (first week), OCTOBER 13-17, 1980 (optional second week): *Cardiac Rehabilitation Workshop* offered through the joint effort of the LaCrosse Exercise Program and LaCrosse Lutheran Hospital/Gundersen Clinic, Ltd. Will provide indepth understanding and experience of all aspects of cardiac rehabilitation and a thorough understanding of the organizational and administrative aspects of a cardiac rehabilitation program. First week will consist of didactic lecture with structured laboratory experiences and examinations while the "optional" second week will allow the individual the opportunity to become involved as a "staff participant" in selected aspects of the LaCrosse Cardiac Rehabilitation Program. Accreditation through a number of agencies is offered. Further info: Workshop Unit—LaCrosse Exercise Program, Mitchell Hall, University of Wisconsin-LaCrosse, LaCrosse, Wis 54601 (608/785-8686).

OCTOBER 11, 1980: *3rd Annual Northwoods Colorama Retreat: Emergency and Primary Care* at Eagle River. Program features seminars individually tailored to the needs of MDs, RNs, and EMTs. Fee: MD/$30; EMT/$25. Six hours AMA Category I. National Registry Credit applied for. Six hours UW Continuing Education Hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706.

OCTOBER 15, 1980: *One-Day Seminar for Family Physicians.* St Vincent Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

OCTOBER 15-17: *The Sociopath 1980: A Practical Inquiry,* symposium and workshop addressing the problems of the community, the cop, the court, the classroom, and the clinician. Sponsored by the University of Wisconsin and the Mendota Mental Health Institute. Info: Bernadine Eve Bednarz, MSW (phone 608/263-4431) or write UW-Extension, 414 Lowell Hall, 610 Langdon St, Madison, Wis 53706.

OCTOBER 17-18, 1980: *Wisconsin ACEP/EDNA Fall Symposium,* Hyatt Regency, Milwaukee. ACEP member fee $125, nonmembers $150. Approved 12 credit hours of Category I of the PRA-AMA. Info: G L Gerschke, MD, 2025 E Newport Ave, Milwaukee 53211 or 414/961-3507.

OCTOBER 24-25: *Orthopedics for the Practicing Physician.* Wisconsin Center, and University of Wisconsin Clinical Science Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education, and University of Wisconsin-Madison, School of Medicine, Department of Orthopedic Surgery. Fee: $125. AMA Category I credit hours applied for. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

OCTOBER 25, 1980: *24th Annual Clinic Day Program: Nutritional Update—1980.* Approved for four hours Category I CME/AAFP credit. Info: Medical Education Office, St Joseph's Hospital, 5000 W Chambers St, Milwaukee 53210.

OCTOBER 28-29, 1980: Wisconsin Work Week of Health, Sentry Insurance Company, Stevens Point, and Heritage House, Madison.

NOVEMBER 5-7: *Aging and Illness in Primary Care—Basic and Clinical Science Foundations.* Wisconsin Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and University of Wisconsin-Madison, School of Medicine, Departments of Medicine and Family Medicine and Practice. Fee: $215. 21 credit hours Category I of AMA; AAFP credit. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 7: Wisconsin Orthopedic Society meeting, starting at 9:00 am, Olympia Princess, Scottsdale Resort, Oconomowoc.

NOVEMBER 6-8: *2nd Annual Respiratory Critical Care Symposium: Acute Respiratory Failure—Admissions to Discharge.* The Inn on the Park, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Pro-

gram Unit and the University of Wisconsin Center for Health Sciences. Fee: $150/physician; $100/nurse, resident, allied health professional. 15 credit hours of Category I of AMA and Family Physician credit applied for. 1.5 CEU units. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 12, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

NOVEMBER 15-16, 1980: *Therapeutics II—1980.* UW Clinical Science Center, Madison. Fee: $115. Credit: Nine hours Category I AMA applied for; AAFP credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone 608/263-2856.

ILLINOIS—1980

NOVEMBER 2-7: Annual Meeting, American Academy of Ophthalmology, McCormick Place, Chicago, Illinois. (Relocated from New Orleans to accommodate increasing attendance.) Info: AAO, 1833 Fillmore St, PO Box 7424, San Francisco, CA 94120, or call 415/921-4700.

ILLINOIS—1981

MARCH 2-6, 1981: Seventieth Annual Meeting of the United States-Canadian Division of the International Academy of Pathology, at the Palmer House, Chicago, Illinois. The Maude Abbott Lecture entitled "The Impact on Time on the Diagnosis and Treatment of Cancer: 1936-1981," will be de-

STATE MEDICAL SOCIETY OF WISCONSIN PRESENTS

ONE-DAY SEMINAR FOR FAMILY PHYSICIANS

St Vincent Hospital - Green Bay
Wednesday, October 15, 1980
Obstetrics & Gynecology
10:00 am - 12:15 pm

Urinary Stress Incontinence; The Management of Abnormal "Pap" Smears; Ectopic Pregnancy; Gestational Dating; Fetal Assessment; Pelvimetry; Breech Delivery; Cesarean Section; Indications for Ultrasound in Obstetrics & Gynecology; Clinical Questions from the Audience - ***Herbert F Sandmire, MD*** and ***Loren L Thompson, MD,*** Green Bay

ENT for the Family Physician
1:00 pm - 3:30 pm

Diagnosis & Management of the Most Common ENT Tumors, ***John K Scott, MD,*** Madison

Causes, Treatment and Complications of Serous Otitis Media, ***S W Vanderwood, MD,*** Green Bay

Bellin Memorial Hospital - Green Bay
Wednesday, November 12, 1980
A Day of Nephrology
10:00 am - 12:30 pm

Clinical Interpretation of Renal Function Tests; Hematuria, Proteinuria, ***Royce Lin, MD,*** Green Bay

1:15 pm - 3:45 pm

Acute Renal Failure, ***Aroor Vishnu Moorthy, MD,*** Madison

Chronic Renal Failure, ***Walter F Piering, MD,*** Milwaukee

A Teaching Service of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

Approved for 4 hours of credit (per meeting) in Category I of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

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For registration materials and program, return the form below to Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701

Name _____
Address _____
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livered by Dr Lauren V Ackerman on March 3. Scientific papers, poster sessions, twelve specialty conferences, and 50 short courses are scheduled. A special course will be offered on "Immunopathologic Techniques in Diagnostic Pathology," with Dr Robert T McCluskey as course director. The long course will be on "The Inflammatory Process and Infectious Disease," with Doctors Guido Majno and Ramzi Cotran, course directors. Further info: Dr Nathan Kaufman, Secretary-Treasurer, United States-Canadian Division of the IAP, 1003 Chafee Avenue, Augusta, Ga 30904; telephone: 404/724-2973. g7-12/80

OTHERS—1980

OCTOBER 6-9, 1980: Joint international educational forum in family medicine, at Rivergate Exhibition Center in New Orleans. Composed of the American Academy of Family Physicians' (AAFP) Annual Scientific Assembly and the Ninth World Conference on Family Medicine of WONCA, the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. More than 7,000 family physicians from 40 countries are expected to participate. AAFP's Congress of Delegates meets October 4-6 at the New Orleans Hilton. Info: AAFP, 1740 West 92nd St, Kansas City, Mo 64114 (phone: 816/333-9700).

OCTOBER 9, 1980: *Hypertension in Family Practice: Evolving Concepts.* Please note: Grand Ballroom A, New Orleans Hilton, Poydras on the Mississippi River, New Orleans, LA. This symposium has been accepted as a special presentation immediately following the Annual Meeting of the American Academy of Family Physicians. Info: World Health Information Services, Inc, 475 Fifth Ave, Suite 505, New York, NY 10017. Phone: 212/679-6200. 9/80

OCTOBER 9-10, 1980: *5th Annual Cancer Screening and Detection Symposium* sponsored by University of Texas System Cancer Center, M D Anderson Hospital and Tumor Institute Division of Cancer Prevention. Holiday Inn, Medical Center, Houston, Tex. Info: Judy E Patterson, RN, M D Anderson Hospital, 6723 Bertner Room PR-855, Houston, Tex 77030. Phone: 713/792-3427. g9/80

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Toll free number 1-800/362-9080.

OCTOBER 9-11, 1980: National conference to explore the role of medical determinations in workers' compensation proceedings, in Washington, DC. Conference concerned primarily with three areas of workers' compensation: (1) the application of current medical knowledge to causality assessment and disability evaluation in heart disease, cancer traumatic neurosis, and lung disease; (2) the usefulness of medically developed standards in workers' compensation rulings; and (3) the presentation of medical evidence in workers' compensation cases. Conference is intended for attorneys engaged in workers' compensation litigation, physicians who examine, evaluate and treat patients seeking compensation, insurers who evaluate such claims, and administrative agency personnel who adjudicate compensation proceedings. Faculty: Jack B Abramson, Esq of Reisman, Milberg, Abramson & Magro, PC, New York, NY; and John T Coyne, Esq of Carr, Jordan, Coyne & Savitts, Washington, DC. Sponsor: American Society of Law and Medicine, 520 Commonwealth Ave, Suite 211, Boston, Mass 02215; or call 617/262-4990.

OCTOBER 9-11, 1980: *American Cancer Society National Conference, Gynecologic Cancer*—1980. Los Angeles Hilton, Los Angeles, Calif. Approved 16 hours prescribed credit AAFP and Category I of the AMA-PRA. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference—Gynecologic Cancer—1980, 777 Third Ave, New York, NY 10017. g8-9/80

OCTOBER 17-18, 1980: Third National Invitational Conference for Physician Negotiators, at the Hilton Hotel, Las Vegas, Nevada. Designed for those involved with negotiations activities, for medical society leaders and executives, and for physicians who have attended one of the AMA seminars and desire to keep informed on negotiations. Contact: AMA Dept of Negotiations, 535 North Dearborn St, Chicago, Ill 60610; or call 312/751-6652.

OCTOBER 19-24: *Annual Clinical Congress, American College of Surgeons,* Atlanta, Georgia. Info: ACS, 55 East Erie St, Chicago, Ill 60611; (312) 644-4050, ext 324.

OCTOBER 24-25, 1980: *Clinical Staffing in Prepaid Group Practice HMOs: A Conference for Medical and Nursing Directors,* at the Radisson South Hotel, Minneapolis, Minnesota. Sponsored by the Medical Directors Division of the Group Health Association of America, Inc. Speakers: Charles A Branthaver, MD, Medical Director, Group Health Service Plan; Conrad Rosenberg, MD, Director, Community Health Program of Queens-Nassau, Inc; Irving N Klitsner, MD, Associate Medical Director, Southern California, Permanente Medical Group; Donald F Schaller, MD, Co-executive Director, Arizona Health Plan; Robert McAlister, MD, Chief-of-Staff, Group Health Cooperative of Puget Sound; Gordon V K Reid, MD, Associate Medical Director, Community Health Care Center Plan, Inc; Jean Steel, RN, MS, Boston University School of Nursing; Marcia Hoch, RN, MS, Director of Nursing, Harvard Community Health Plan, Inc; Sheila McCarthy, RN, ANP, Office of Health Maintenance Organizations, Department of Health and Human Services; Harvey P Katz, MD, Vice President, Patuxent Medical Group, Columbia Medical Plan; Charlotte Hill, MD, Administrative Physician, Group Health Plan; Jane Cassels Record, PhD, Senior Economist, Kaiser/Permanente Health Services Center of Portland, Oregon; Jerry Hoferber, Administrative Assistant to the Chief-of-Staff, Group Health Cooperative of Puget Sound; and Marcia Hoch, RN, MS, Director of Nursing, Harvard Community Health Plan, Inc. Certified for 10 hours CME Category I credit by the AMA and by the Liaison Committee for CME. Info: Medical Directors Division, Group Health Association of America, 1717 Massachusetts Ave, NW, Washington, DC 20036.

OCTOBER 24-26: *American Academy of Neurological and Orthopaedic Surgeons.* Contact: Michael R Rask, Program Chairman, 2320 Rancho Drive, Suite 108, Las Vegas, Nev 89102.

OCTOBER 19-24: *American Academy of Physical Medicine and Rehabilitation,* Washington, DC. Contact: Barry Miller, PO Box 995, Ann Arbor, Mich 48106, 313/572-3562.

OCTOBER 26-30: Annual Scientific Assembly of the American College of Chest Physicians, at the Sheraton Boston Hotel and Hynes Auditorium Convention Center, Boston, Mass. *CAT Scanning—Cardiopulmonary Disease* and *Detection, Diagnosis, and Management of Lung Cancer* are two of the six subjects to be discussed in the major symposia sessions. Full-day programs discussing such topics as occupational lung disease, critical care, perfusion technology, respiratory care, and echocardiography will be presented. Over 30 hours of credit may be obtained toward Category I of the PRA-AMA. Further info: Dale E Braddy, Director of Education, ACCP, 911 Busse Highway, Park Ridge, Ill 60068.

NOVEMBER 3-6: 65th Annual Scientific Assembly of Interstate Postgraduate Medical Association at the MGM Grand Hotel, Las Vegas, Nev. Info: Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701. g7-9/80

DECEMBER 6-11: American Academy of Dermatology, New York, NY. Info: AAD, Inc, 820 Davis St, Evanston, Ill 60201 (Phone 312/869-3954).

OTHERS—1981

APRIL 23-25, 1981: *American Cancer Society National Conference on Human Values and Cancer: Psychological, Social and Ethical Issues.* Washington Hilton Hotel, Washington, DC. 15½ credit hours of Category I of AMA/PRA. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference on Human Values and Cancer, 777 Third Ave, New York, NY 10017. g9tfn/80

MAY 2-22, 1981: *Program in Health Policy, Planning and Regulation,* conducted at the Harvard School of Public Health by an interdisciplinary faculty drawn from the Harvard Graduate Schools of Public Health, Business, Law, Medicine, Government, and Arts & Sciences. Intensive training in management and analytic skills for senior leaders in health delivery and health-related organizations. Info: Assistant Director for Administration, Executive Programs in Health Policy and Management—Dept NR, 677 Huntington Ave, Boston, MA, 02115.

JUNE 21-JULY 31, 1981: *Program for Health Systems Management,* conducted at the Harvard School of Public Health by an interdisciplinary faculty drawn from the Harvard Graduate Schools of Public Health, Business, Law, Medicine, Government, and Arts & Sciences. Focuses on the managerial skills of leadership, resource allocation and institutional policy and strategy required by senior executives in health industry organizations. Info: Assistant Director for Administration, Executive Programs in Health Policy and Management—Dept NR, 677 Huntington Ave, Boston, MA 02115.

AMA—1980

DECEMBER 7-10: Interim AMA House of Delegates, San Francisco Hilton, San Francisco, Calif.

AMA—1981

FEBRUARY 12-15: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9: Interim AMA House of Delegates, Las Vegas Hilton, Las Vegas, Nev.

AMA—1982

FEBRUARY 25-28: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8: Interim AMA House of Delegates, Fountainbleu Hilton, Miami, Fla.

CHILDREN AND TEENS brochure that addresses talking book and braille reading services for children and teenagers who are visually or physically handicapped. Bulk copies of this brochure are available for distribution to patients. For copies write to: Publication Services, National Library Service for the Blind and Physically Handicapped, The Library of Congress, Washington, DC 20542.

INFANT FEEDING

THE PUBLIC HEALTH Nutrition Program of the Wisconsin Division of Health, Department of Health and Social Services, has developed new materials on infant feeding for distribution to parents and caretakers of infants and toddlers. The new material is in the form of a series of 11 leaflets, each dealing with a single topic on feeding the very young child. These are:

- —Breast Feeding
- —Commercial Formula Feeding
- —Bottling
- —Weaning
- —Introducing Solid Foods
- —Feeding Babies: The Commercial Way
- —Vegetarianism: Diet for a Little World
- —Feeding Problems
- —Feeding Your Toddler: Diet After the First Year
- —Homemade Baby Foods
- —Teething

Quantities of these leaflets are available to physicians for distribution to their patients. Contact Division of Health, PO Box 309, Madison, Wis 53701; or phone (608) 266-1511.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

DANE CMS REVIEWS CONCERNS OVER PREMARITAL EXAMINATIONS. At a recent meeting of the Dane County Medical Society's Board of Trustees, the trustees reviewed concerns expressed by the State Registrar's Office and the County Clerks Association over the extent of physical examinations given couples under the state requirements stated in Section 745.60, Wisconsin Statutes. As reported in the DCMS *Bulletin* the "Board considers the following as complying with the state requirement:

"1. RPR or VDRL or similar serologic test for syphilis;

"2. An examination of the anogenital area for evidence of venereal disease;

"3. As indicated, cultures taken for gonorrhea, smear or culture taken for herpes progenitalis, a scraping for confirmation of a diagnosis of scabies, possible biopsy or removal of venereal warts or perhaps other cultures as appropriate to rule out other significant sexually transmitted diseases;

"4. A limited office examination is appropriate as determined by the physician's judgment.

"The Dane County Medical Society Board of Trustees feels that the practice of giving complete physical examinations or representing complete physical examinations as mandatory as part of statutory requirements is wrong. It is understood that certain patients will request complete examinations by their physicians; however, no misrepresentation may be made by examining physicians. The Dane County Clerk has been asked to report to DCMS any specific instances in which physical examinations appear to be more complete or otherwise outside the above stated guidelines for investigation. Meanwhile, a committee of county government representatives and a physician representing the State Medical Society is studying the potential for removing the specifics of examination, laboratory, and certificate from the statutes. These would be included in an administrative rule, allowing flexibility as technology and disease patterns change."

MEDICAID UPDATE. Physicians Alliance commissioners and staff are maintaining extremely close contact with the day-to-day developments concerning the Governor-ordered 4.4% budget cut as it impacts on the Medicaid program.

Last month, DHSS Secretary Donald Percy indicated in a memo to Governor Lee Dreyfus that one method of saving state dollars in the Medicaid program would be to delay the July 1980 increase in physician reimbursement. Because DHSS has decided to implement the 4.4% reduction in Medicaid expenditures across all providers, physicians would have to "contribute" approximately $1.4 million to the reduction between now and July 1, 1981.

Every July 1 physician Medicare profiles are updated to reflect charges made in the previous year—in this case calendar year 1979. This update may not exceed a level set by the Federal Department of Health and Human Services utilizing the Federal Medical Economic Index.

For this year that factor is 1.658 of the 1979 charges, which would translate into an 8.5% increase. Funds could be saved if DHSS were to not "pass along" this increase, or by "decreasing the increase" to save the 4.4%. Therefore, the adjustment to physician Medicaid reimbursement may be in the neighborhood of a 4% increase rather than an 8.5% increase for the fiscal year July 1980 through June 1981.

The SMS Physicians Alliance is reviewing several options available to the State Medical Society as a response to this DHSS move not to increase physician reimbursement. Mr Percy has indicated that the Department will save the 4.4% and that provider reimbursement is the target for savings. Changes in the T-19 benefit package or eligibility standards would require action by the full Legislature or at a minimum action by the Legislature's Joint Committee for Review of Administrative Rules; actions which are not likely in an election year and by legislative bodies controlled by Democrats.

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WISCONSIN MEDICAL JOURNAL

OCTOBER 1980

• *Special* Modern mental health legislation: "Crime of logic"? • *SMS Organizational* SMS states position on 4.4% budget cut / 1980-81 Membership Roster to be published in January • *News you can use:* New law allows for payment of Title II SS disability medical claims

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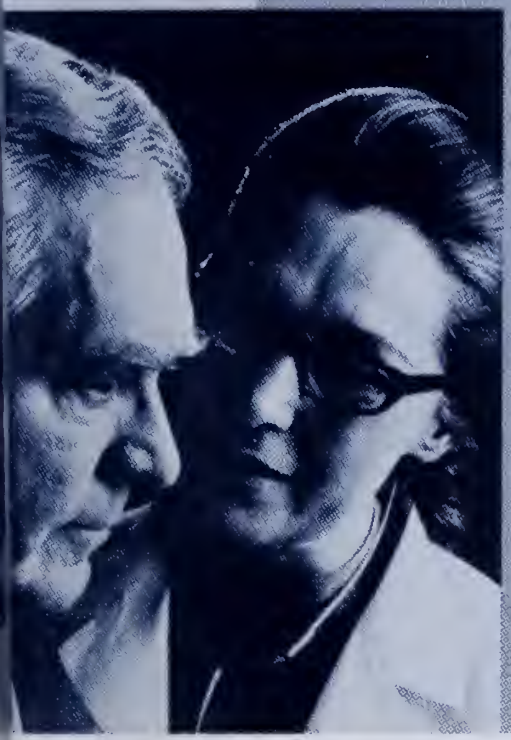

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Contraindications: Patients with known hypersensitivity to the drug

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function Paradoxical reactions (e g . excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges In a few instances syncope has been reported Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy

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WISCONSIN MEDICAL JOURNAL

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Full disclosure epidemic

THE CARTER administration's leak of military secret information (Project Stealth) shocked a lot of citizens, but actually those who were surprised by the release of such sensitive information just haven't been paying attention to what's been going on all over the country the past ten years.

For some inexplicable reason there is an epidemic afoot on a national scale characterized by an overwhelming desire among those afflicted to blab everything they know to anyone who will listen without any regard whatsoever for the consequences. The causative agent, thus far unidentified, is of such virulence that its victims are powerless to resist and must speak out even if they aren't certain of the accuracy of their pronouncements, and must continue to ventilate until every last detail is exhausted. No walk of life is immune—least of all the healing arts.

No one knows how it all began, but certainly Watergate accelerated its development. The truth must out! Nowadays the patient must be told all the gruesome details of his forthcoming operation or diagnostic test and all possible untoward happenings must be listed; and if the doctor happens not to be afflicted by the blabbermouth disease, one of the nurses or relatives almost certainly will be. As a matter of fact, nurses seem to be especially vulnerable and seem compelled to discuss the results of the operation with the patient even before the effects of anesthesia have been completely dissipated.

Two instances which took place less than a month ago in one physician's practice illustrate the depth of the grasp of the epidemic:

An 80-year-old woman, admitted with obstructive jaundice, at operation was found to have carcinoma of the head of the pancreas. A palliative biliary tract bypass was accomplished with complete relief of her symptoms. But her daughter, a nurse, insisted that she be told her diagnosis and how long she was expected to live.

An 89-year-old man at the time of cholecystectomy (for acute cholecystitis) was found to have carcinoma of the gallbladder. His 81-year-old wife was told the findings and was also told that the carcinoma of the gallbladder would eventually reappear and cause his death. Every time she visited she asked if the doctor had told him yet, and she couldn't understand the delay.

I suppose all physicians have developed their own rules as to what a patient should know, and what works for one of us might not be acceptable at all to another. The age, personality, education, and level of responsibility of the patient all come into play in deciding the depth of disclosure. But I can't believe that the current craze to spill all is in the best interest of the patient. I do know that the decision must be made by the responsible physician after discussion with the family, and that all other parties involved with the patient's care have to remain close-mouthed no matter how great the urge to do otherwise.—WJB

$$ New procedures $$

WITH THE passage of time fees for most medical-surgical services become fairly standard, at least on a regional basis; and physicians, their patients, and insurance carriers tend to live with them without too much disagreement.

Problems arise, however, when new procedures are developed for which no track record has been established. It doesn't take a genius to figure out that the best way to get rich quick is to set the fee high right off the bat with the hopes that it will become the norm. Recent examples which come to mind are charges for coronary bypass surgery and the various endoscopic manipulative procedures. In the beginning the complexity of coronary bypass may have warranted a high fee, but with refinement and simplification, no reduction in fees occurred.

The latest new procedure, percutaneous transluminal angioplasty (a method of dilating stenotic or occluded peripheral arteries with a balloon positioned under fluoroscopic, angiographic control), has engendered some really astounding bills. Insurance companies are now trying to determine what a fair charge is by contacting consultants in specialties dealing with peripheral vascular diseases in the hope that the standard will be set at a reasonable level. Some of the charges for iliac artery dilation, for instance, done under local anesthesia, have been much higher than the usual and customary fee for bilateral aortofemoral bypass. And to make matters worse the operators have

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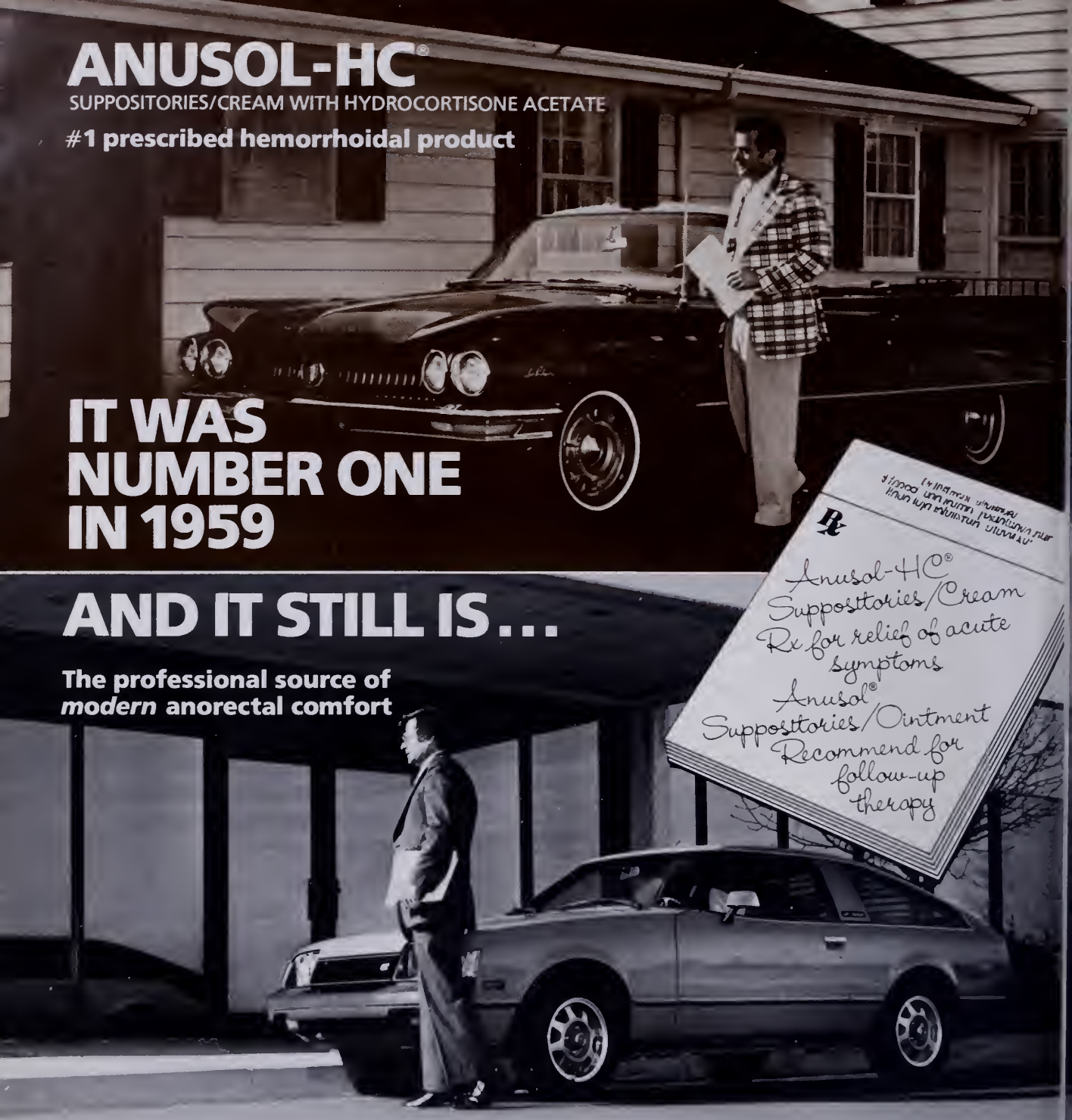

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tacked on charges for the angiography and pre- and postoperative visits as well.

Reasonable consultants can do their communities a real service here by simply stating that such fees are outlandish and unethical and should not be paid. Specialty society leaders must recognize that the practice of medicine is not a business in which charges can be escalated until the breaking point is reached. They must clamp down on their colleagues who believe they have a right to enrich themselves quickly at the expense of a captive public.—WJB

Celiac disease

GASTROENTEROLOGISTS, hematologists, and immunologists have long been aware of the immunologic dysfunction and frequent development of malignancy in patients with adult celiac disease. Although lymphoreticular neoplasms are most frequent, multiple myeloma has not previously been reported in association with this bowel disease. Doctors Ershler, Mosher, and Barreras of the University of Wisconsin Center for Health Sciences briefly report such a case in this issue. Because of its brevity the authors did not submit photomicrogaphs of the various biopsy specimens, but they are available upon request. —VSF ■

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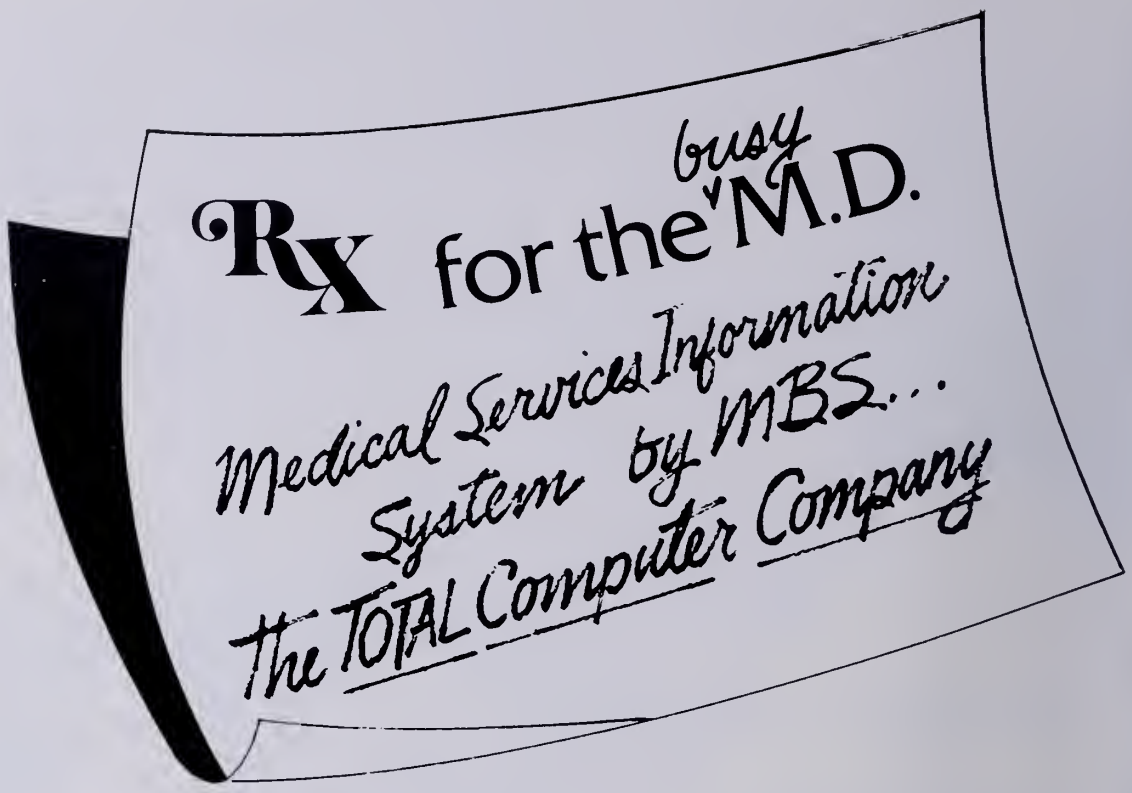

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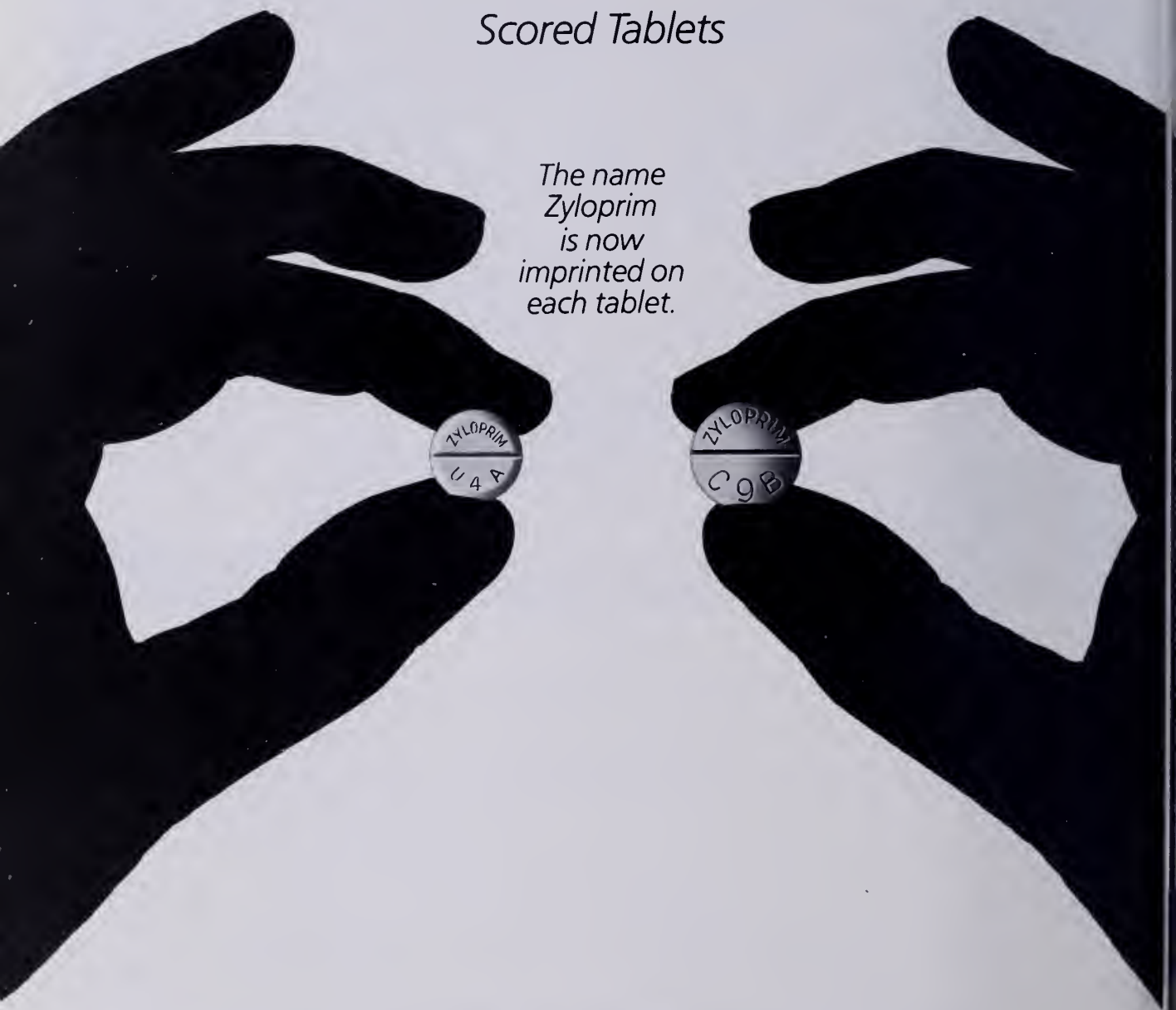

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Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Closing of PA program unrealistic

THE MARSHFIELD Medical Foundation should be justly proud of its pioneering efforts in establishing an academic program for training physician assistants. However, to justify closing a program in which 71 of the 97 graduates have found employment in rural Wisconsin (with the increasing number of graduate physicians), is unrealistic (*WMJ,* July 1980, Vol 79). Further, to consider a termination of a PA program because of the emergence of a training program for nurse practitioners is unjust, as the *differences* in curriculum, task inventories, and scope of practice in these two healthcare providers are so great. The reality of the situation is:

1. There continues to be a maldistribution of primary care physicians in rural areas—the areas in which PAs are traditionally employed.
2. There remains a need in Wisconsin for legal foundation for the practice of nurse practitioners, especially in the areas of independent practice as advocated by nurse practitioners versus dependent practice as advocated by PAs.
3. The statement made in the WMJ article, that many out-of-state trained PAs can come into Wisconsin and find employment, merely attests to the fact that the PA concept is alive and well in Wisconsin—and a definite need has been identified.
4. The recent Federal census for the first time has noted a shift of population from the large urban areas to the more residential areas of our state, reinforcing the need for primary care providers willing to practice outside of metropolitan areas.

Undoubtedly, all of the reasons considered in the termination of the Marshfield Medical Foundation PA program were not listed in the *WMJ* article by Mr Payne, Mr Stelton, and Doctors Sautter and Nikolai—but the reasons stated certainly do not justify such action!

Timothy D Bauer, PA-C
President, Wisconsin Academy
of Physician's Assistants (WAPA)
VA Medical Center
Tomah, Wisconsin

Response to "Dear Ms Jones"

I AM WRITING in response to your (WJB) editorial (Dear Ms Jones) published in the April 1980 *Wisconsin Medical Journal* and reprinted in the September-October 1980 issue of *STAT.* I believe it is fitting that I should give you a brief resume of my background so that you can appreciate where I am coming from.

I graduated from St Olaf College, a Christian Liberal Arts college, with a BSN in 1966. From 1966 until 1978, I worked in a variety of hospital settings in Minnesota, North Dakota, and Wisconsin. These hospitals ranged in size from 20 beds to 600 beds and my responsibilities varied from specialty areas to all areas of patient care. For two of those twelve years I taught nursing students at the Papuan Medical College in Port Moresby, Papua—New Guinea.

I appreciate your concern for my profession and its practitioners and I wish to thank you for taking the time to voice your concerns. I, too, have struggled with some of the issues you delineate.

As I am sure you have experienced in your practice, the paper work has increased greatly over the years. I do not enjoy charting or filling out innumerable forms and I am reasonably certain there are many nurses who share my sentiments. At the same time that I say that, I appreciate the importance of appropriate and accurate charting in the overall care of patients. Continuity of care is enhanced when charting is done well. Doctors, as well as other nurses, can be kept informed of the patient's progress by reviewing the chart. Patients going from one department or facility to another are more apt to receive appropriate, continuous care when charting is pertinent and updated. And then, of course, there is the problem of lawsuits which may be averted by proper documentation of care. What I am saying is that, although "paper work" is not direct patient care, it is nevertheless important to direct patient care. Unfortunately, it is impossible to do paper work and direct patient care simultaneously and nurses must decide the best time for each. Many times I would stay on after "change of shift" to chart without remuneration—because direct care came first. It does not seem fair that one should be in fact punished (longer hours, less pay) for being conscientious.

My frustration with the decreasing amount of time I was able to spend with patients—listening, talking, educating, and caring—coupled with the ever increasing responsibilities for which there was little acknowledgement of the importance of nursing to total patient care prompted me, in 1978, to return to the University and get my MSN in Primary Care. I am now a Family Nurse Practitioner working in joint practice with a Family Practitioner Physician. In this setting, both medical and nursing skills and expertise can be seen as complementary and equally important functions in total patient care. Our roles are not interchangeable in spite of much overlap. We are appreciated for our unique contributions to the team as well as our united efforts. Although this is very satisfying, far more important is the belief that our patients receive an enhanced quality of care.

I wish to make one more comment. You wrote about nurses engaging in the study of psychology, sociology, and counseling, and I believe suggested that these trends have encouraged us to lose sight of the motives that steered us into nursing. I cannot speak to the variety of motives that lead people into a profession, but perhaps I can make a point by reviewing my motives. I pursued nursing because I was concerned about people and had a special interest in the sciences. These interests could have led me to medicine, nursing, or a variety of other fields, but nursing had a special appeal to me. In it I saw a way to deal with people physically, mentally, spiritually, and socially. Approaching people on only one level is, I believe, incomplete and unsatisfactory. The more one can understand about the complexities of people and the way they act and interact, the better one can meet their needs and help them to identify and meet their own needs and, in so doing, approach a sense of total well-being. Some of us come by this understanding intuitively, but I certainly believe the study of the sciences, arts, and humanities help us gain insight into human nature and in turn be better nurses—and doctors.

Lillian J Nordin, RN, MSN
Primary Care Nurse Practitioner
Route 1, Box 138
Merrill, Wis 54452

Fewer breech deliveries in Wisconsin?

IN REFERENCE to some statistics in an article, "Increase in Cesarean Deliveries in Wisconsin," in the July issue of the Journal, I have a question regarding the incidence of breech deliveries in Wisconsin.

In the article, according to health and medical data on Wisconsin birth certificates, Bureau of Health Statistics, and State Division of Health, breech delivery rates are ranging 6.77 to 3.88 per 1000 deliveries (0.677%-0.388%) from 1968 through 1977 in decreasing order.

It is not my intention to discuss whether or not this declining tendency is true. To me this breech delivery rate in Wisconsin is, by far, lower than usual. Two to five percent is the usual breech rate in obstetric textbooks.[1,2,3]

Are there really fewer breech deliveries in Wisconsin? I do not believe so. In fact, the breech delivery rate in my own practice in the same geographical area from 1975 through 1980 is 3.6% (36/1000 deliveries) regarding which I would like to publish in the near future in this Journal.

The Journal's statistics don't seem misquoted or misprinted, but the discrepancy may be based mostly on the fact that physicians completing birth certificates did not describe the deliveries fully and precisely. For instance, they may be stating "fetopelvic disproportion" or malpresentation instead of "breech presentation;" no note of presentation at the time of repeat Cesarean section, and so on. If this certificate is to be used for statistic purposes, it is not clinically accurate.

This information given as such is not to be considered all physicians' faults. The birth certificate currently used may be simple but not precise enough to show proper information. Many obstetric practitioners know the form can be devised to a better one. I do not want to describe how this could be done at this time but would like to see the opinions of the editor and other readers.

Tetsuo Tagawa, MD
Obstetrician-Gynecologist
Hartford, Wisconsin

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Modern mental health legislation: "Crime of logic"?

Kurt Hoehne, MD, Winnebago, Wisconsin

OUR SERVICES to the mentally ill are drifting into an ever-widening chaos. This chaos disadvantages particularly those patients who are unable to understand that they need help and can get help. Their distraught and long-suffering families together with the mental health professionals are legislated to stand by helplessly as needless destruction takes its gradual and sometimes terrible toll. The recent formation of Alliances for the Mentally Ill all over the country is but one outcry of many against this inhumane legislation. In my fifty years in medicine in four western countries, I have never seen anything like these recent developments here.

The determination of who needs help and treatment and when he needs it, what kind of treatment may be given, how it should be given, how long treatment may be given, where it must or must not take place, how much "acting out" may be considered dangerous, how much consideration may be given to the hapless families, just to name a fraction of the issues, depends to a large extent on court hearings and court decisions based mainly on nonmedical principles and considerations. Small wonder then that the medical profession, so enthusiastic about psychiatry two decades ago, is rapidly turning away from what has become more a legal battlefield than a medical specialty. I have overheard frustrated, angry families remark bitterly that to them the Mental Health Act looks more like a lawyer's employment act. Cosmetic changes as we have just tried them in Wisconsin will not alter the total picture.

The concepts leading to these unfortunate developments are clear and simple. Our constitution states that no person should be deprived of liberty without due process of law, and the law should protect everyone equally. A free person then will arrange his place in society to his own satisfaction and ability, and all is well. However, there are persons who are unable to use or even tolerate that liberty, who need protection instead. Do the words "equal protection of the laws" (14th Amendment) refer exclusively to legal procedures? Could we not accept the true meaning of the words, namely that our laws should protect such a person from foreseeable harm?

The famous philosopher Immanuel Kant warned us in 1783 in his "Prolegomena" that "all illusion consists in holding the subjective ground of judgment to be objective." In other words, the fact that a thought or concept appears to be logical and morally appealing does not necessarily mean that it will work out well in the real world. In 1911 the neo-Kantian philosopher Hans Vaihinger elaborated Kant's warning in his book "The Philosophy of As If" and cautioned us that we should not mistake thought processes for copies of reality itself.

It is one thing to talk about liberty, dangerousness, and informed consent in the formulation of a law, and it is quite another thing to know what their true meaning is in reality in every given case, under the pressures and limitations of the courtroom. The logical functions of the mind are working according to their own laws which are by no means always identical with the principles working in the real world. Logic is merely a technology of thinking, like nailing is a technology of putting pieces of wood together. A technology as such does not assure usefulness of its result in the real world.

Mankind has always relied on guidance derived from abstract ideas, sometimes with great success, at other times with disastrous consequences. Just two of many examples for the latter should be given. The elaborate logical justification of the ill-famed inquisition of one of our churches, conceptualized by some of the best theological scholars in their times caused the sacrifice of the lives of thousands of people whom we would nowadays consider fine, innocent and courageous human beings. The concept and development of sovereign national states resulted in the mutual slaughter and mutilation of millions of people who had no personal quarrels with each other. Two worldwide wars and countless smaller ones in our own 20th century give testimony to the power abstract ideas can exercise. It seems that the human race is ready anytime to sacrifice some of its members to certain logical albeit over-valued concepts. The horrors created by such misapplied logic made the French poet Albert Camus cry out about "Crimes of Logic."

Reprint requests to: Kurt A Hoehne, MD, Chief of Service, Forensic Observation Unit, Winnebago Mental Health Institute, Winnebago, Wis 54985 (phone: 414/235-4910). Copyright 1980 by the State Medical Society of Wisconsin.

The people who conceived and formulated the modern mental health legislation were just as deeply and honestly convinced that they were creating something good and constructive as were the legislators who worded the 14th Amendment. However, the logical "subjective ground of judgment," no matter how sincerely applied, is not necessarily a safe guide through the complexities of the real world. Reality can only be experienced. With all this in mind, it often looks as if we are sacrificing our patients and their welfare to our theoretical concepts by forcing liberty on them before all else, although they need protection and help more than anything else. Would it be wrong to grant "equal protection of the laws" to them in a more humane way until such time when they can enjoy liberty again as we do? Is it really so difficult to correct this needless "Crime of Logic"? ■

SPECIAL ISSUE—Mental Health

The WMJ's Editorial Board has approved a special issue featuring mental health to be published in early 1981. Charles W Landis, MD of Milwaukee, chairman of the SMS's Committee on Mental Health, will be the guest editor. Anyone wishing to contribute material should contact Doctor Landis at 414/271-5555, or write him at St Mary's Hill Hospital, 2350 North Lake Dr, Milwaukee, Wis 53211.

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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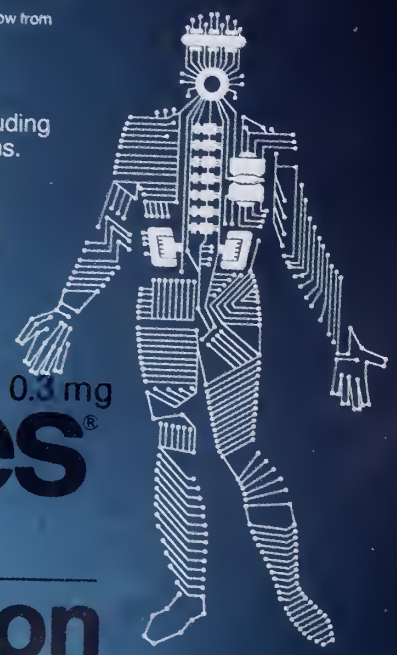

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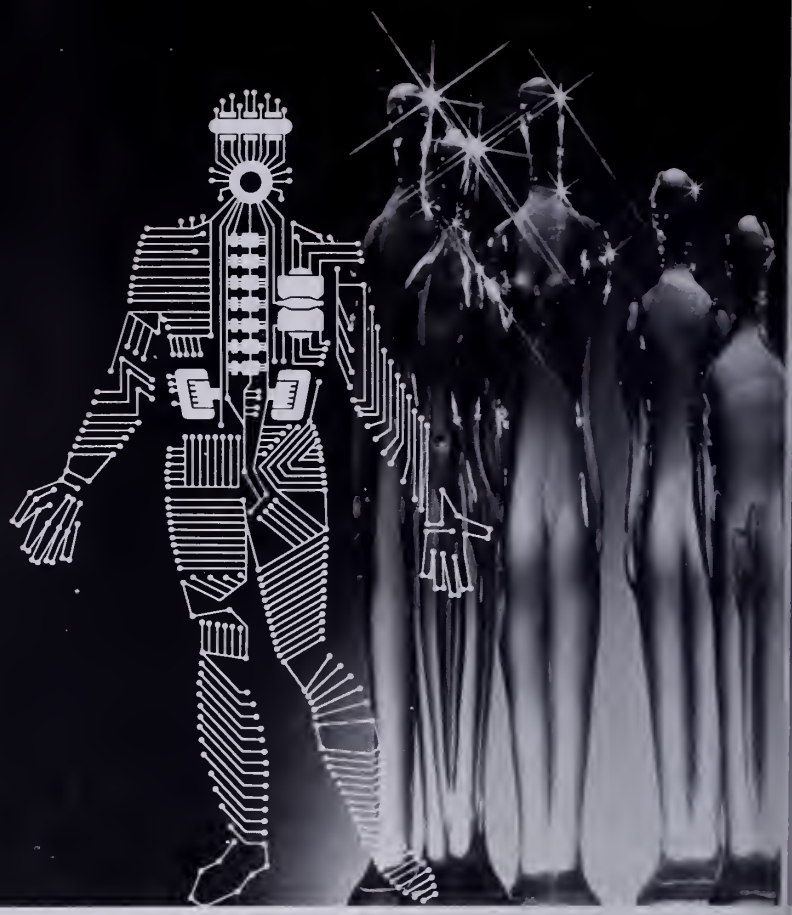

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Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 longer.

Adverse Reactions: The most common reactions are dry mouth, drows sedation. Constipation, dizziness, headache, and fatigue have been Generally these effects tend to diminish with continued therapy. The reactions have been associated with the drug, some of them rarely instances an exact causal relationship has not been established.) Thes Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnor liver function tests; one report of possible drug-induced hepatitis with and hyperbilirubinemia in a patient receiving clonidine hydrochlor thalidone and papaverine hydrochloride. Weight gain, transient elevatio glucose, or serum creatine phosphokinase: congestive heart failure phenomenon; vivid dreams or nightmares, insomnia, other behavioral nervousness, restlessness, anxiety and mental depression. Also gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not with a rash, impotence, urinary retention, increased sensitivity to alcoho itching or burning of the eyes, dryness of the nasal mucosa, pallor, gyne weakly positive Coombs' test, asymptomatic electrocardiographic abr manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminis sent reflexes and vomiting followed the accidental ingestion of Catapres hydrochloride) by several children from 19 months to 5 years of ag lavage and administration of an analeptic and vasopressor led to co covery within 24 hours. Tolazoline in intravenous doses of 10 mg at intervals usually abolishes all effects of Catapres, (clonidine hydrochlo dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

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Scientific Medicine

REFER TO—Bosch A, Frias Z, Pellett JR Carcinoma of the esophagus; twenty-five years' experience at the University of Wisconsin Hospitals. *Wisconsin Med J* 79:23-26 (Oct) 1980

KEY WORDS—Esophageal carcinoma

Carcinoma of the esophagus: twenty-five years' experience at the University of Wisconsin Hospitals

Antonio Bosch, MD; Zenaida Frias, MPH; and John R Pellett, MD
Madison, Wisconsin

ALTHOUGH CANCER of the esophagus is not as frequent in the United States as in Africa, China, India and Japan, it represents 1% of the 765,000 cancer cases diagnosed annually; and about 8400 new cases are seen each year.

Cancer of the esophagus is generally diagnosed in advanced stages of the disease, and treatment results still remain poor in spite of advances made in surgical techniques and in the use of megavoltage radiotherapy units.

The present study reports the experience of 25 years in the management of carcinoma of the esophagus at the University of Wisconsin Hospitals in Madison.

MATERIAL. During the period from 1950 to 1974, 331 patients with biopsy-proven diagnosis of carcinoma of the esophagus were seen in our institution. Eighty-two percent were male, and the median age was 65 years. Tumor localization was as follows: 18% were upper third lesions, 57% were middle third, and 25% were in the lower third of the esophagus. Sixty-five percent had lesions which measured over 5 cm. The pathologic diagnosis was squamous cell carcinoma in 95%, adenocarcinoma in 4%, and other types 1%.

In only 99 patients, or 30% of the series, the tumor remained localized to the esophagus. Infiltration of the surrounding esophageal structures and/or metastases were found at the time of diagnosis in 28% (93 patients), and in 33% (108 patients) extension of the tumor to surrounding structures or metastases to lymph nodes or organs were found on exploration. Spread of the tumor was determined in 5% (15 patients) shortly at follow-up, and at autopsy in 5% (16 patients).

TREATMENT. Of the 331 patients 81, or 24%, were treated with curative intent with surgical resection. The surgical procedures in most patients were total esophagectomy with esophagogastric anastomosis or colon interposition. Sixty-one patients (18%) received a curative dose of irradiation of 5000 to 6000 rad in five to six and one-half weeks.

One hundred fifty-eight patients (48%) were treated with palliative intent, in view of the advanced stage of the disease, metastases, or poor general condition. The palliative procedures involved palliative radiotherapy in 109 patients, plastic process in 12 patients, colon interposition in 7, jejunostomy in 9, and gastrostomy in 21 patients.

Thirty-one patients, or 9%, of the series did not receive any treatment. Table 1 shows the distribution of patients by treatment modality and by extent of disease.

Ninety-nine of the 331 patients had localized disease; 73 of them were treated with curative intent, 27 with surgery, and 46 with irradiation. Twenty-six of the 99 localized cases received palliative or no treatment in view of the massive

From the Divisions of Radiation Oncology and Thoracic Surgery, University of Wisconsin Center for Health Sciences, Madison, Wisconsin. This study supported in part by NCI Grant No 5PO1CA19278-04. Publication support provided. Reprint requests to: Division of Radiation Oncology, K4/B100, 600 Highland Ave, Madison, Wis 53792 (phone: 608/263-8500). Copyright 1980 by the State Medical Society of Wisconsin.

Table 1—Location and extension of disease, by treatment modality

TREATMENT MODALITY	LOCATION (THIRD) Upper	Middle	Lower	TOTAL NUMBER OF CASES	EXTENSION Localized (Intraesophageal)	Extraesophageal spread
CURATIVE						
Resection	3	45	33	81	27	54
Radiotherapy	21	37	3	61	46	15
PALLIATIVE						
Radiotherapy >5000 rad	7	27	11	45	—	45
Radiotherapy <5000 rad	19	37	8	64	15	49
Palliative procedures						
Plastic process	—	6	6	12	2	10
Colon interposition	1	5	1	7	—	7
Jejunostomy	2	3	4	9	1	8
Gastrostomy	2	11	8	21	3	18
NO TREATMENT	6	17	8	31	5	26
TOTAL	61	188	82	331	99	232

Table 2—Survival by treatment modality

TREATMENT MODALITY	NUMBER OF CASES	PERCENT SURVIVAL (BY YEAR) 1	2	3	4	5
CURATIVE						
Resection	81	42	21	17	14	12
Radiotherapy	61	39	18	11	10	7
PALLIATIVE						
Radiotherapy >5000 rad	45	13	2	0	0	0
Radiotherapy <5000 rad	64	9	3	0	0	0
Palliative Procedures	49	4	0	0	0	0
NO TREATMENT	31	0	0	0	0	0
TOTAL	331	22	9	7	5	4

intraesophageal lesion or because of poor general condition; 15 received palliative irradiation, gastrostomy was performed in 3 patients, in 3 other a celestine tube was placed, and 5 patients were not treated.

RESULTS. Only 14 patients, or 4%, of the 331 survived five years: 5 resected lower third lesions, 3 resected middle third, 2 middle third lesions who had radiotherapy following resection, and 4 upper third lesions treated with curative radiotherapy.

In the group of 99 patients whose lesions were localized to the esophagus, 73 had radical treatment, 27 of whom were considered candidates for surgical resection after exploratory thoracotomy revealed no extension of the tumor outside the esophageal lumen, nor any metastases to the regional lymph nodes; 13 of these 27 patients died within 30 days post-resection, 7 died with recurrent disease, and 7 were alive five years after surgery. The remaining 46 patients who received radical treatment were treated with irradiation, as they were considered poor risks for surgical exploration or refused surgery; only 4 were alive at the end of five years. Twenty-six other patients received palliative treatment or were not treated, and none survived five years.

All of the 158 patients receiving palliative treatment died before five years. The 21 patients in whom a gastrostomy for feeding purposes was performed died by the end of six months, the 9 patients having a jejunostomy for the same purpose died by 15 months, and the 12 patients in whom a plastic process was placed, died by 16 months. Only 5% of the 109 patients who received palliative irradiation were alive at the end of 18 months. All of the 31 patients who were not treated died before 10 months. Survival by treatment modality is presented in Table 2.

POSTOPERATIVE MORTALITY. Twenty of the 81 patients (25%) who had surgical resection of

Table 3—Total experience with cancer of the esophagus

AUTHOR	YEAR	NUMBER OF CASES	NOT TREATED OR PALLIATION	SURGERY ONLY	RADIATION ONLY	COMBINED RADIATION & SURGERY
CLIFFTON et al (USA)[1]	1926-65	1786 (1.4)	403 (0.0)	345 (3.0)	912 (1.0)	126 (6.0)
PEARSON (England)[5]	1931-64	1640 (5.4)	882 (0.4)	443 (9.9)	315 (12.7)	
PETROV (Russia)[6]	1945-65	1344		249 (2.8)		
NAKAYAMA (Japan)[4]	1946-65	4816		1900 (6.3)		64 (37.5)
BOSCH et al (USA)	1950-74	331 (4.2)	189 (0.0)	81 (12.3)	61 (6.6)	
LEBORGNE et al (Uruguay)[3]	1950-59	361 (2.5)	67 (0.0)	0	294 (3.1)	
BEATTY et al (Canada)[7]	1958-72	738 (4.4)	562 (0.0)	6	146 (6.0)	18
DESAI et al (India)[2]	1965-66	1120 (2.2)	884 (0.0)	31 ( )*	205 (9.2)	

( ) Parentheses indicate percent five-year survival.
*Survival at three years of 19%.

the esophagus died within the 30-day period postsurgery. The operative mortality for the period from 1950 to 1959 was 40% (15 of 37 patients), while that for the subsequent period 1960 to 1974 was 12% (5 of 42 patients).

Ninety-three other patients were initially explored but not resected; the postoperative mortality in this group was 13% (12 of 93 patients).

DISCUSSION. The absolute five-year survival for patients with carcinoma of the esophagus varies from 1.4% to 5.4% in large series of cases reported in the literature.[1-6] Our five-year survival rate of 4.2% for the 331 cases studied in our series is in agreement. In the majority of institutions more than half of the patients do not receive any treatment, or receive only palliative treatment for the relief of symptoms; and the five-year survival for these patients is close to zero. Selected patients are treated radically and with curative intent with either surgery, radiotherapy, or a combination of both modalities; but the results obtained are still poor. The results obtained in various cancer centers, where large numbers of patients with esophageal carcinoma are treated, are shown in Table 3.

The treatment modalities employed in the management of cancer in general, and of esophageal cancer in particular, are modified according to the evaluation of the results obtained at the various institutions. Such an evaluation of the different treatment modalities or their combinations is only possible in cancer centers where a large number of cases is treated, and where surgeons and radiotherapists are conscious of the problem and collaborate in trying to improve the results. This evolution has not yet occurred in the majority of institutions. Esophageal cancer patients usually are referred to the department of surgery, where the operable patients are selected, and only those considered inoperable due to advanced age, poor general condition, medical contraindications to surgery, patients with advanced or metastatic disease, and those who are found to be unresectable at exploration are then referred for radiotherapy.

To improve the results of treatment in carcinoma of the esophagus, there are several areas which require special attention and those are: epidemiology, prevention, early detection, and improvement in treatment modalities.

The epidemiologic studies should be undertaken in areas of high incidence such as China, India, Africa, Puerto Rico, Brazil, Japan, Iran, Northwest France, and others.[8] Prevention of carcinoma of the esophagus may be enhanced by reduction in alcohol intake and tobacco consumption, and also by improving the nutrition of the populations at risk.

Early diagnosis by means of exfoliative cytology[9,10] or radioesophagogram[11] may be of value in high-risk populations. Also of importance is the reduction of the patient and physician delay in diagnosis and treatment.

The surgical results may be improved by better selection of the cases amenable to surgery, experience of the surgeons in the management of patients with carcinoma of the esophagus, reduction in the morbidity and operative mortality which is related to the expertise of the surgeon,

Editorial Note: In the February 1980 *Wisconsin Medical Journal* O'Connor, Watson and Weisel reported on their five-year experience with cancer of the esophagus. They concluded that palliation continued to be the best thing they had to offer and that they preferred cobalt therapy for squamous cell carcinoma of the esophagus. However, for patients with adenocarcinoma involving the esophagus, resection, whenever possible, was their treatment of choice.—VSF

and to the selection of the cases; and perhaps by the use of adjuvant preoperative irradiation.

The radiotherapy results may be improved by better selection of patients for curative treatment. Use of megavoltage high-energy treatment units and high LET particulate radiation should be investigated. Better tumor localization of the esophageal lesion and its extension should be pursued, as well as evaluation of optimal dose and treatment volume for preoperative irradiation and adjuvant modalities such as hyperthermia, radiosensitizers, and cytotoxic agents.

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Abstracts

Penicillin susceptibility of *Streptococcus pneumoniae* in 1978; screening for resistance by disk testing

DENNIS G MAKI, MD; ARLAN G HELSTAD, MS; and JUDY L KIMBALL, BS (University of Wisconsin Hospitals, Center for Health Sciences, and State Laboratory of Hygiene, Madison, Wis): *Am J Clin Pathol* 73: 177-182, 1980

Recently, strains of *Streptococcus pneumoniae* with greatly increased resistance to penicillin (minimal inhibitory concentrations or MICs, 1-8 μg/ml) were recovered in cultures of blood from patients in South Africa and from one in Minnesota who had serious pneumococcal infections. The authors undertook a study to determine whether these resistant strains have become prevalent in their locale. Between January and July 1978, the laboratories of hospitals serving the greater Madison, Wisconsin, area (population 200,000) contributed 243 pneumococcal isolates for susceptibility testing by an agar dilution technic. Strains with greatly increased resistance (MICs $\geq$ 1.0 μg/ml) were not found; only six strains (2.4%) had relative resistance to penicillin (MICs .125−.50 μg/ml), a range of susceptibility that has been associated with inconsistent clinical responses to treatment with penicillin. Overall, the susceptibility patterns of these 243 isolates are similar to those reported from other centers in North America over the past 30 years. Routine susceptibility testing of pneumococci by hospital laboratories in our area does not appear to be necessary now, but laboratories are advised to screen blood and spinal fluid isolates by a disk-diffusion method. Studies of these 243 isolates and seven South African multiply-resistant strains using a modified Kirby-Bauer technic, showed that a zone of inhibition less than 35 mm around a 10-unit penicillin disk, or better, less than 17 mm around a 1-μg oxacillin disk, correlates strongly ($P<.001$) with resistance to penicillin (MIC $\geq$.1 μg/ml). ■

Freshwater wound infection due to *Aeromonas hydrophila*

PETER G HANSON, MD; JON STANDRIDGE; FREDRIC JARRETT, MD; and DENNIS G MAKI, MD (University of Wisconsin Center for Health Sciences, Madison, Wis): *JAMA* 238:1053-1054 (Sept 5) 1977

Aeromonas hydrophila is a Gram-negative bacillus, member of the family Vibrionaceae, which is a common inhabitant of freshwater lakes and streams. It is not commonly identified as an agent of human infection. Most reports have described gastroenteritis, septicemia, meningitis, pneumonia, or surgical wound infections, primarily in immunocompromised patients.

Infections of immunologically competent persons have been rare. The authors reported a well-documented case of severe cellulitis in a previously healthy young man that derived from a laceration acquired during swimming in Lake Mendota. *Aeromonas hydrophila* was recovered in large numbers from the wound and was subsequently shown to be the major bacterial contaminant of the freshwater lake where the injury occurred. The clinical features of *Aeromonas* infections of freshwater traumatic wounds suggest a characteristic syndrome, indistinguishable from cellulitis caused by a group A Streptococcus. Surgical drainage combined with appropriate antimicrobial therapy was effective. ■

REFER TO—Sty JR, Casper JT, Oechler HW: Bone scintigraphy: retroperitoneal fibrosis. *Wisconsin Med J* 79:27-28 (Oct) 1980

KEY WORDS—Bone Imaging, retroperitoneal fibrosis, histiocytosis

BONE SCINTIGRAPHY: Retroperitoneal fibrosis

John R Sty, MD; James T Casper, MD; H W Oechler, MD, Milwaukee, Wisconsin

A 13-YEAR-OLD male, previously healthy, was suffering from malaise, intermittent fever, weight loss, and low back pain. On admission his physical examination was normal except for limitation of truncal movement. His hemogram showed an elevated white blood cell count, anemia, and increased sedimentation rate. Urine analysis was normal. A roentgenogram of the lumbosacral region and excretory urogram were normal (Fig 1A).

A bone scan using 8.3 mCi/m^2 of 99m methylene diphosphonate showed numerous areas of abnormal tracer accumulation in the axial and appendicular skeleton (Fig 1B). Biopsy of a tibia lesion and manubrial lesion demonstrated nonspecific inflammatory change. Cultures for bacteria, fungi, and mycobacteria were negative. Tests for tularemia, rickettsiosis, brucellosis, histoplasmosis, blastomycosis, leptospirosis, and toxoplasmosis also were negative. No diagnosis was established. The child's fever and back pain increased, and a repeat bone scan was performed. The study demonstrated no new areas of bone involvement. However, an obstructed ureter was noted at the level of the fourth lumbar vertebra (Fig 2A). An intravenous pyelogram was performed because of the scintigraphic abnormality. The excretory urogram showed medial displacement of the distal ureters with obstruction (Fig 2B). This finding suggested retroperitoneal fibrosis. The patient was taken to surgery and the diagnosis of retroperitoneal fibrosis was confirmed. Several lymph nodes were obtained for histologic

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Figure 1A—Normal excretory urogram.

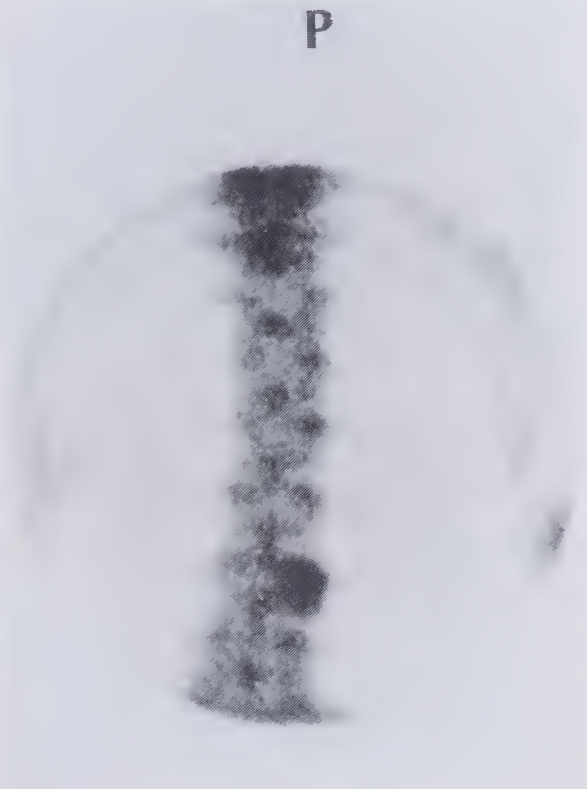

Figure 1B—Posterior bone image. Focal abnormality of a fourth lumbar pedicle. No evidence of obstructive uropathy.

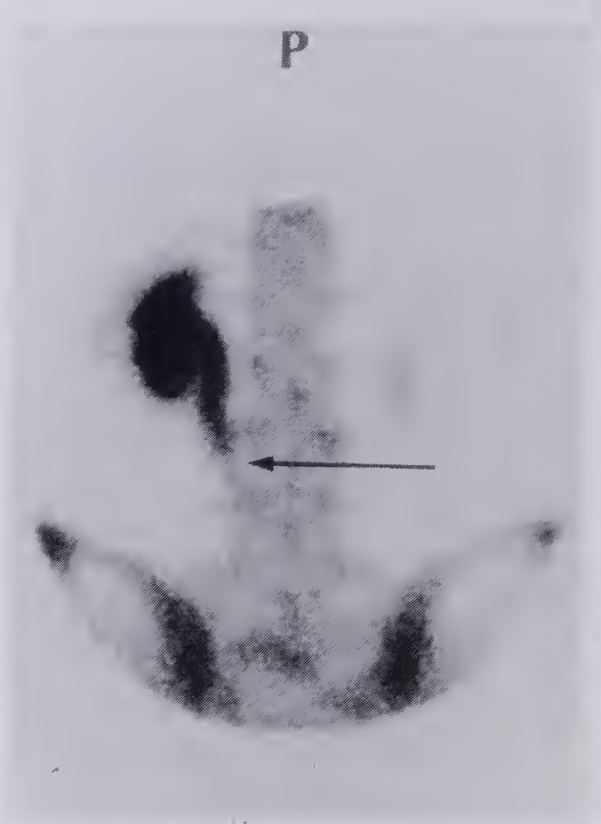

Figure 2A—Posterior bone image. Arrow marks obstructed ureter.

Figure 2B—Excretory urogram. Obstructed ureter with bilateral medial deviation of the ureters.

examination. The lymph node examination proved the child had malignant histiocytosis.

Extrinsic ureteral obstruction by retroperitoneal fibrosis is predominantly an adult disease; however, several cases in children have been recorded.[1,2,3] Retroperitoneal fibrosis may be idiopathic or secondary to malignancy or infection. In children the disease is usually idiopathic.

Because of the mechanism of tracer excretion, bone imaging agents provide clinically important information regarding the urinary system in children with malignancy.[4] Bone imaging was useful in detecting retroperitoneal fibrosis in the case illustrated, and selected more specific examinations that confirmed the diagnosis.

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DRUG NEWS

Roche's Librax® product

A preliminary injunction in favor of Roche Products Inc. was issued on September 3, 1980 by Judge Vincent P. Biunno of the U.S. District Court of New Jersey. The order prohibited Premo Pharmaceutical Laboratories, Inc. from producing, advertising, selling, or offering to sell any product containing the active ingredients of Roche's Librax ® product in a light green capsule similar to the Roche product. Judge Biunno termed Premo's copying of the Roche Librax trade dress "an unprivileged imitation of the physical appearance" of Roche's Librax. Premo was also enjoined from stating, suggesting or implying in any manner, direct or indirect, that its product is the same as, similar to, or comparable with Roche's Librax.

REFER TO—Henderson PA, Curet LB, Olson RW, Schwartz DB: The treatment of premature labor with isoxsuprine. *Wisconsin Med J* 79:29-33 (Oct) 1980

KEY WORDS—Premature labor, isoxsuprine, obstetrics, perinatology

The treatment of premature labor with isoxsuprine

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FOR THREE YEARS premature labor was managed in 101 patients with intravenous isoxsuprine. Delivery was postponed for 72 hours in 45 of 79 patients with intact membranes (57%). With ruptured membranes delivery was postponed in only 2 of 22 patients (9.1%). Labor was more easily postponed with minimal or no dilation of the cervix. In patients with intact membranes and in whom delivery was postponed for 72 hours, the birthweights were significantly increased over those in whom labor suppression was unsuccessful. This was not true for patients with ruptured membranes. There were 12 neonatal deaths, four of which would probably not have been prevented by suppressing premature labor. A corrected neonatal death rate was 7.0%. Maternal complications of intravenous isoxsuprine were common, but could be controlled with close supervision and monitoring of the patient and taking corrective measures when appropriate. Inhibition of premature labor remains a significant perinatal problem in spite of current isoxsuprine therapy.

PREMATURE LABOR continues to be a major problem in obstetrics. It is becoming an increasing problem especially for perinatologists in referral centers. "Mother is the best transport incubator" is an often quoted dictum as efforts are made to transport more women in premature labor, rather than transporting the premature newborn after the delivery has already been accomplished. This allows the obstetrician, or perinatologist, an opportunity to suppress the labor and hopefully gain additional time for the fetus to mature in utero.

The variety of therapeutic regimens that is used in an effort to suppress premature labor is a testimony to their relative ineffectiveness. Also, the high incidence of false labor makes accurate diagnosis of true premature labor difficult. To further complicate the issue, a placebo effect has been observed in 38% to 73% of patients treated for premature labor.[1,2]

From the Wisconsin Perinatal Center, Southcentral Region, The Department of Obstetrics and Gynecology, University of Wisconsin Medical School, Madison. Publication support provided. Reprint requests to: Wisconsin Perinatal Center, Madison General Hospital, 202 South Park St, Madison, Wisconsin 53715. Copyright 1980 by the State Medical Society of Wisconsin.

In recent years the treatment of premature labor has consisted of a number of pharmacologic agents. There are at least three groups of drugs, acting by different mechanisms, which have been used. These are alcohol, prostaglandin inhibitors, and the β mimetic adrenergic agents.

Alcohol inhibits the release of endogenous oxytocin and antidiuretic hormone from the pituitary gland, and it also has a direct effect on the myometrium.[3] Zlatnik and Fuchs[1] showed that 17 of 21 patients (81%) had delivery postponed at least 72 hours with intravenous alcohol administration compared with 8 of 21 (38%) patients treated with 5% glucose in water.

Another theory for the initiation of human labor is the release of prostaglandins. Accordingly, a number of investigators postulate that the inhibition of prostaglandin synthesis may be of therapeutic value in the suppression of premature labor.[3] Salicylates were assessed initially, and then subsequently, indomethacin, naproxen, and fenoprofen have all been investigated. Although there have been studies of women in premature labor successfully treated with indomethacin administration, there is a significant problem. Prostaglandins also mediate the smooth muscle tone of the ductus arteriosus, and so theoretically, prostaglandin synthetase inhibitors can precipitate the premature closure of the ductus arteriosus in utero when administered to pregnant women.[3] More careful studies are needed before these drugs can be recommended for the treatment of premature labor.

Since 1961 when Bishop and Woutersz[4] used intravenous isoxsuprine to treat premature labor, this drug has been used for this purpose. In the early 1970s, we were attempting to establish a tertiary high-risk maternity center and the referrals of patients in premature labor were encouraged in an effort to prophylactically address the problem of prematurity. At that time we chose isoxsuprine as the agent with which to attempt to suppress premature labor and developed a protocol for its use. The purpose of this report is to describe three years' experience with intravenous

isoxsuprine utilized in a regional referral center for the treatment of premature labor.

METHODOLOGY. During the three years, 1976-1978, our program utilized intravenous isoxsuprine for the treatment of premature labor and patients were included if they were between 24 and 37 weeks gestation. They were considered in premature labor if their contractions were every 10 minutes or less. The drug was used only if there was a live fetus and there was an absence of maternal or fetal conditions for which ordinarily delivery would be indicated; *eg,* severe hypertension, severe preeclampsia, intrauterine infections, or fetal distress. Patients with ruptured membranes were included.

The patient was hydrated with an intravenous infusion of 1000 ml of Ringer's lactate over a 30 to 60 minute period. A Foley catheter was inserted into the bladder, and she was placed in the lateral supine position in bed. The maternal hydration with Ringer's lactate was continued and the isoxsuprine begun via secondary intravenous line using a controlled infusion pump to deliver an initial dose between 0.1 and 0.25 mg per minute. This dosage was increased every 10 to 15 minutes by 0.1 to 0.2 mg per minute increments to a maximum dose of 1.0 mg per minute. Hourly intake and output was measured and the maternal pulse and blood pressure were obtained every 15 minutes. Fetal heart rate and the uterine contraction patterns were monitored with one of several Corometric external fetal monitors.

Once the desired response of contractions, at least 15 minutes apart for one and one-half hours was obtained, the patient was weaned gradually decreasing the infusion rate over a 30-minute period. Ten milligrams of isoxsuprine was given intramuscularly just prior to weaning, and another 10 mg was given intramuscularly at the end of the 30-minute weaning period. Twenty milligrams of isoxsuprine was given intramuscularly every three to four hours for the next 48 hours. The intravenous hydration was continued for 24 hours after weaning from the intravenous isoxsuprine. If uterine contractions recurred at a frequency greater than every 15 minutes, the intravenous administration of isoxsuprine was repeated until the desired response was obtained and then the weaning process repeated as described. The patient remained at bed rest until she was on the oral medication for 24 hours. She was then progressively ambulated unless contractions recurred.

RESULTS. The success of isoxsuprine to arrest labor in this study was defined as postponing delivery for 72 hours or greater. According to this definition, our overall success rate was 46.5% (Table 1). In a smaller sample of patients pre-

Table 1—Delivery interval related to status of membranes

Interval between isoxsuprine and delivery	Membranes ruptured No.	(%)	Membranes intact No.	(%)	Totals No.	(%)
< 72 hours	20	(90.9)	34	(43.0)	54	(53.5)
≥ 72 hours	2	(9.1)	45	(57.0)	47	(46.5)
TOTALS	22	(100.0)	79	(100.0)	101	(100.0)

Table 2—Description of patients at time of treatment

Status of membranes Hours delivery postponed	No. of patients	Cervical dilatation (Mean)	Weeks gestation (Mean)
Membranes intact			
< 72 hours	34*	1.97	32.2
≥ 72 hours	45+	.93	32.1
Probable significance (p)		<.001	NS
Membranes ruptured			
< 72 hours	20	.95	31.7
≥ 72 hours	2	1.0	29.5
Probable significance (p)		NS	NS

* For cervical dilatation n = 33 (Cervix not evaluated because of bleeding)
\+ For cervical dilatation n = 41

viously studied, delivery was postponed in two of eight patients with ruptured membranes. On the basis of this 25%, it was decided to include patients with ruptured membranes in the current study. However, as can be seen in Table 1, we were successful in postponing labor for greater than 72 hours in only 2 of 22 patients (9.1%). If we exclude those patients with ruptured membranes from the analysis, then we were successful in postponing delivery longer than 72 hours in 45 of 79 patients, or 57.0%.

Cervical dilatation. In considering the group of patients with intact membranes, the degree of cervical dilatation was greater in those who were delivered within less than 72 hours of treatment than those patients in whom delivery was postponed for greater than 72 hours. The mean cervical dilatation was 1.97 cm in the former group, and 0.93 in the latter, for a statistically significant difference with a *p* value of less than .001 (Table 2). There were five patients who received isoxsuprine but who had a moderate degree of vaginal bleeding so that the cervix was not examined. In those patients with ruptured membranes there was no significant difference between those who were delivered prior to 72 hours following treatment as opposed to postponing delivery for greater than 72 hours. Because of our previous experience, labor suppression was not attempted if the cervix was dilated more than 4 cm.

Gestational age. There was no significant difference in gestational age between those patients delivered less than 72 hours following the initiation of isoxsuprine therapy and those in whom delivery was postponed for greater than 72 hours (Table 2).

Birthweight. For those patients with intact membranes who delivered within 72 hours of therapy, the mean birthweight was 1843.8 gm. The mean birthweight of infants delivered of mothers in whom delivery was postponed for greater than 72 hours was 2618.6 gm. This difference is significant with a *p* value of less than .001. In those patients with ruptured membranes and who delivered within 72 hours of therapy, the mean birthweight was 1973.8 gm as compared to 3118.5 gm for those patients in whom delivery was postponed for 72 hours. Because of the small numbers, these mean values were not significantly different.

Neonatal deaths. There were several patients with multiple gestations so that the 101 patients gave birth to 115 infants (Table 3). In those patients with intact membranes and who delivered within 72 hours of therapy, there were four sets of twins and one set of triplets. All four of two sets of twins died. These were born at 24 and 28 weeks gestation. The infants weighed 525, 474, 460 and 400 gm. One additional singleton birth weighing 3118 gm died. It was delivered at 33 weeks of a severely Rh sensitized mother who had hydramnios. The infant, delivered by emergency cesarean section for fetal distress, was severely hydropic and lived only a few minutes.

In the group of patients with intact membranes in whom delivery was delayed for greater than 72 hours, there were four sets of twins all of whom survived. The deaths included a 2311-gm infant who died with overwhelming *b* hemolytic streptococcal infection, a 964-gm infant with severe erythroblastosis from Rh incompatability, and a 3317-gm infant of a Class C diabetic mother with major congenital anomalies.

In the group of patients with ruptured membranes there were four deaths, all in the group who were delivered within less than 72 hours of treatment. There was one set of triplets and one set of twins in this group. The twins survived. The triplets who weighed 1191, 1049 and 1120 gm all died with complications of prematurity, including respiratory distress syndrome, sepsis, and necrotizing enterocolitis. The other infant, a singleton, weighed 900 gm and died with sepsis, a patent ductus arteriosus, necrotizing enterocolitis, and renal failure.

Maternal complications. Maternal complications of intravenous isoxsuprine therapy are

Table 3—Outcomes of pregnancy

Status of membranes Hours delivery postponed	No. of newborns	Birthweight (Mean) (Gm)	Neonatal death (No.)
Membranes intact			
< 72 hours	41	1843.8	5
≥ 72 hours	49	2618.6	3
Probable significance		p < .001	
Membranes ruptured			
< 72 hours	23	1973.8	4
≥ 72 hours	2	3118.5	0
Probable significance		NS	

Table 4—Complications of intravenous isoxsuprine therapy

Maternal tachycardia	45
Drug had to be stopped	28
Maternal hypotension	11
Fetal tachycardia	5
Subjective symptoms (nervousness, nausea, dizziness, chest pounding)	5

Table 5—Reasons for stopping isoxsuprine infusion

Labor progressed despite isoxsuprine	11
Maternal hypotension	5
Failure of maximal infusion rate	6
Fetal distress	3
Mature L/S ratio	2
Maternal tachycardia	1
TOTAL	28

listed in Table 4. Maternal tachycardia with a pulse rate over 120 beats per minute was the most common. However, the drug was not necessarily stopped for this reason. Maternal hypotension with a systolic blood pressure of less than 70 mmHg occurred in 11 patients. Intravenous isoxsuprine was stopped on 28 occasions by the attending physician and the reason for stopping the medication is noted in Table 5. More mild and nonspecific complaints which were noted included nasal stuffiness and head congestion, blurring of vision, restlessness, shortness of breath, and a tendency to hyperventilate.

Statistical analysis. The means and standard deviations of the data were calculated and comparisons were made using student t tests. The probability values were taken from two tailed tables and only values less than 0.05 were considered significant.

DISCUSSION. The use of the *b* mimetic adrenergic compounds in premature labor began in the 1960s. The influence of adrenergic agents on the uterus has been known since 1927, and further impetus was provided by Ahlquist in 1948 when he established the concept of *a* and *b* receptors in smooth muscle systems.[5]

In 1967 Lands and his associates proposed a subdivision of the receptors into β-1 receptors found in the heart and small intestines, and β-2 receptors found in the bronchi, vascular beds, and the uterus.[6] This stimulated a search for new compounds which would have specific β-2 activity. Isoxsuprine was the first of these drugs to be used clinically. In general its cardiovascular side effects were so common, however, as to limit its use to large medical centers. Recently the search for more specific β-2 compounds has produced a whole new series of drugs which have been directed toward treatment of premature labor; *eg,* ritodrine, terbutaline, fenoterol, salbutamol, and buphenin. These drugs, however, are not generally available for treatment of premature labor in the United States, although a number of research protocols have been published. Niebyl and her associates have a comprehensive review on the subject of the pharmacologic inhibition of premature labor.[3]

Intravenous administration of isoxsuprine has been used by a number of investigators to arrest premature labor. Bishop and Woutersz[4] were successful in arresting premature labor for more than seven days in 44% of cases. Hendricks and co-workers[7] postponed delivery for greater than 11 days in six of nine patients treated with isoxsuprine. Castren[2] and his co-workers postponed delivery for seven days in 62% of his patients treated with isoxsuprine as compared to 77% treated with buphenin, 56% treated with ethanol, and 73% treated with a placebo. Csapo and Herczeg[8] were able to stop premature labor with isoxsuprine in 84% of their cases for 21 days as contrasted to 24% in the placebo group.

This present study demonstrated an overall success rate of only 46.5%. This was improved to 57.0% if patients with ruptured membranes were excluded. Success was defined as postponing delivery for 72 hours. A 57% postponement of delivery is not a particularly dramatic success rate. Nevertheless, several significant points can be made about this drug which has enjoyed rather popular use.

1. We corroborated the finding of other investigators in documenting the poor success in arresting premature labor of patients who have ruptured membranes. We were able to postpone delivery for longer than 72 hours in only 2 of 22 patients (9.1%).

2. In those patients in premature labor with intact membranes, the greater the cervical dilatation the more difficult it was to stop labor. Conversely, we were more successful in stopping labor in those patients whose cervix was undilated or minimally dilated.

3. There were 12 neonatal deaths in our series of 115 births. Of these, four would probably not have been salvaged even if labor had been suppressed until term. There was (1) a 2311-gm infant who succumbed to β hemolytic streptococcal infection, (2) a 3317-gm infant of a diabetic mother with major congenital anomalies, (3) a 3118-gm infant with severe hydrops from Rh disease, and (4) a 964-gm infant with severe erythroblastosis from Rh disease.

The eight remaining neonatal deaths were probably related to prematurity. Four of these were in two sets of twins where both twins died. The premature labor started in these patients with intact membranes and labor suppression was

unsuccessful. All four of the infants weighed less than 600 gm. The other four deaths included one set of triplets whose mother entered with ruptured membranes and was delivered of infants weighing 1049, 1120, and 1191 gm, all of whom died. These deaths emphasize the need for a labor suppressant effective in patients with ruptured membranes. The fourth neonatal death was a 900-gm infant whose mother had ruptured membranes and the infant succumbed with sepsis.

The neonatal mortality of 10.4% if corrected for the deaths not attributable to prematurity was 7.0%.

4. Despite its popular use as a drug to suppress premature labor, isoxsuprine still leaves much to be desired. Although its β-2 activity is sufficient to inhibit premature labor in a little over one-half of the patients, its β-1 effects were prominent. Unless enough drug was administered so that maternal side effects were apparent, the attempt to suppress labor was apt to be unsuccessful. The complications encountered are listed in Tables 4 and 5.

When maternal complications did occur, they were amenable to stopping the drug, placing the patient in Trendelenburg position and increasing the primary intravenous infusion rate. In no instance was it necessary to administer vasopressors or propranolol. We agree with Hendricks and his co-workers[7] that the well-hydrated subjects appear to tolerate the drug better than those who are not hydrated prior to administering the isoxsuprine. The hypotensive response can be minimized by having the patient in the lateral supine position during the infusion. Constant supervision and physician attendance during intravenous therapy is imperative. This drug should be used only in major medical centers where the personnel are trained and skilled in its use.

5. β mimetic agents are known to cause hyperglycemia.[9] Isoxsuprine is no exception and this was especially noticeable in those instances in which premature labor in diabetic patients was being suppressed. In fact, some consider diabetes a contraindication for the use of the β mimetic agents. Recognizing this effect, however, we found that the blood glucose levels could be maintained in the euglycemic range by judicious use of intravenous insulin.

SUMMARY. This report has reviewed the three-year experience with the treatment of premature labor with isoxsuprine. The results showed the drug not to be very effective and associated with significant side effects. Newer β mimetic compounds are currently being tested and perhaps soon one of these will be available, be more effective, and associated with fewer side effects.

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Abstracts

Steel needles used for intravenous therapy; morbidity in patients with hematologic malignancy

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We studied the morbidity associated with steel needles used for intravenous therapy in adults with hematologic malignancy. Of 148 needles, 52 (36.1%) produced local inflammation, increasing with placements exceeding 24 hours, use of dextrose-containing infusate or intravenous antibiotics, granulocytopenia, and local infection. Eight needles (5.4%) caused local infection and three (2.1%) caused septicemia. Of nine bacteremias occurring in the 43 study patients, none of the five caused by Gram-negative bacilli, but three of the four caused by staphylococci, originated from steel needles. Five of eight local infections and all septicemias occurred with placements exceeding 72 hours; each patient with septicemia was granulocytopenic. Intravenous steel needles are a major source of morbidity in patients with granulocytopenia or who are otherwise immunologically compromised. The insertion site should be routinely rotated at least every three days. Nosocomial staphylococcal bacteremia in granulocytopenic patients is likely to be due to an intravenous needle or similar device used for vascular access. ■

REFER TO—Ershler WB, Mosher DF, Barreras RF: Multiple myeloma and adult celiac disease. *Wisconsin Med J* 79:34-35 (Oct) 1980

KEY WORDS—Celiac sprue, multiple myeloma, celiac disease

Multiple myeloma and adult celiac disease CASE REPORT

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The association of celiac sprue with malignancies, particularly intra-abdominal lymphoma and carcinoma of the gastrointestinal tract,[1,2,3] is well recognized. Celiac sprue is also associated with immunologic abnormalities, such as hypogammaglobulinemia,[4,5] impaired cytotoxicity,[6] poor lymphocyte response to mitogens,[2] and deficient "T" cell number.[7] Additionally, autoimmune disorders occur more frequently in these patients.[8] To our knowledge, however, there has been no reported case of multiple myeloma in association with celiac sprue. We recently treated a patient with chronic diarrhea and postmenopausal osteoporosis who was found to have celiac disease and multiple myeloma when a flare up of her bowel disease necessitated hospitalization.

A 75-YEAR-OLD woman was admitted to the hospital because of diarrhea and abdominal pain. She first experienced protracted diarrhea (20 bowel movements per day) 25 years prior to admission. At that time she was evaluated at a local hospital and reassured that no major gastrointestinal disease was found. She was discharged on a regular diet and within months the diarrhea disappeared. Three years prior to admission the diarrhea recurred. Over the next three years she had four to five bowel movements per day and lost 20 lb. Alterations in her diet did not change the bowel pattern. On the day of admission the patient awoke with severe abdominal pain and a bloating sensation. She was seen in the emergency room and admitted with a diagnosis of partial small bowel obstruction. Shortly after admission to the hospital her abdominal pain subsided.

The patient's mother had a history of persistent diarrhea and anemia prior to her death at the age of 66 years. Her brother has been diagnosed with celiac disease and has been successfully treated with a gluten-free diet. The patient had no skeletal pain and, other than the diarrhea, had been well and active.

On physical examination she had prominent kyphoscoliosis but no lymphadenopathy, hepatosplenomegaly, or bony tenderness. Examination of the abdomen revealed low-pitched bowel sounds, slight tenderness, but no abnormal mass. There was no peripheral edema. The hematocrit reading was 26%, the hemoglobin level was 8.5 gm/dl and the white blood cell count was 1200/cu mm with a differential count of 32 neutrophils, 18 band forms, 45 lymphocytes, 3 monocytes, and 2 metamyelocytes. Platelet count was 2.7 x 10^5, total serum protein was 9.7 gm/dl, albumin was 3.6 gm/dl, calcium was 7.9 mg/dl, blood urea nitrogen was 19 mg/dl, creatinine was 1.1 mg/dl and electrolytes were normal except for a bicarbonate of 19 mmol/L. Serum protein electrophoresis revealed a monoclonal spike in the mid-gamma-globulin region. Immunoelectrophoretic analysis with monospecific antisera identified this monoclonal component as an IgG protein with lambda light chains. An iliac crest marrow aspirate and biopsy demonstrated greater than 80% plasma cells. Skeletal x-ray studies revealed diffuse osteoporosis. Upper gastrointestinal barium contrast radiographic studies were unremarkable, as was the barium enema. Endoscopy, however, revealed that the mucosa of the second portion of the duodenum was atrophic, with readily visualized veins and fine nodularity. Small bowel biopsy revealed shortening and blunting of the villi, and a proliferation of plasma cells in the lamina propria.

The patient was placed on a gluten-free diet, and there was a prompt resolution of the diarrhea. Chemotherapy for her myeloma was initiated with melphalan and prednisone. One year after the institution of the gluten-free diet and chemotherapy, she remains free of diarrhea. Her serum protein was 8.5 gm/dl with a persistent monoclonal spike on electrophoresis. A repeat bone marrow was hypocellular, but 60% of the cells counted were plasma cells.

COMMENT. Diarrhea and steatorrhea are not commonly associated with multiple myeloma. Although plasma cell infiltrates or discrete plasmacytomas are occasionally found in the gastrointestinal tract,[9] the occurrence of these symptoms can more frequently be explained by the appearance of amyloid.

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Although in our patient the diagnosis of celiac disease and multiple myeloma were made within a few days of each other, the long history of intermittent diarrhea and the positive family history suggest that the bowel disease was of long duration. The appearance of malignancy in patients with celiac disease has been well described and several theories have been offered in explanation. An abnormal immune surveillance allowing for the development of a malignant clone of cells is most popular.[1] Proponents of this theory cite the various studies demonstrating a defect in the immune apparatus, such as a reduction in the number of "T" cells or immunoglobulins, or demonstrating a defect in immune function, such as impaired response to mitogens or reduced cytotoxicity. Other explanations include inherent genetic predisposition (celiac patients with malignancy have a higher frequency of having the histocompatibility antigens HLA-A1, HLA-B8, and HLA-B12),[10] and the accumulation of dietary carcinogens because of the lack of detoxifying enzymes and appropriate cell turnover in the small bowel mucosa.[1]

The malignancy that develops in patients with celiac disease is most frequently an intra-abdominal diffuse lymphoma, or a carcinoma of the gastrointestinal tract. With the frequent occurrence of immunologic dysfunction, it is not surprising that malignancies of the lymphoreticular system predominate. This is certainly true of tumors arising in other immune-suppressed patients. Multiple myeloma, a malignant conversion of an immune functioning cell, had not been reported in association with celiac disease. It is tempting to speculate that chronic antigenic stimulation in a patient with abnormal bowel mucosa and an abnormal immune response resulted in the plasma cell dyscrasia. In patients with multiple myeloma who have persistent, unexplained diarrhea or steatorrhea, endoscopy and biopsy are indicated to rule out amyloid or celiac disease.

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Abstracts

Late appearance of arterial emboli: diagnosis and management

FREDRIC JARRETT, MD; GUILLERMO C DACUMOS, MD; ANDREW B CRUMMY, MD; DON E DETMER, MD; and FOLKERT O BELZER, MD, Section of Vascular Surgery, Department of Surgery, University of Wisconsin Center for Health Sciences, Madison, Wis: *Surg* 86:898-905 (Dec) 1979

Although the occurrence of an arterial embolus is usually a cataclysmic event prompting emergency presentation and early diagnosis, we have managed 22 patients who presented more than 48 hours after the onset of symptoms. The diagnosis was apparent in only six patients. The remainder had subacute limb ischemia, and arteriography was used to help delineate the diagnosis in 14 of these patients. In most instances arteriograms were atypical of chronic occlusive disease, rather than diagnostic of arterial emboli. Embolectomy was performed a mean of 13 days after the onset of symptoms, with retrieval of thromboembolic material in all instances. Two patients died (mortality rate of 9%), and the limb salvage rate for the 25 limbs explored was 88%. Among 22 lower extremity embolectomies, foot pulses were restored in 13 patients (59%), and four patients (18%) had viable extremities without pulses. Adjunctive arterial reconstruction was required in three patients. ■

REFER TO— Lello CJ, Lazerson J, Krueger D: Impact of hemophilia home therapy program on a regional blood center. *Wisconsin Med J* 79:36-38 (Oct) 1980

KEY WORDS—Hemophilia, blood banking program, cryoprecipitate

Impact of hemophilia home therapy program on a regional blood center

Cheryl J Lello, MA; Jack Lazerson, MD; and **Donald Kreuger, CPA,** Milwaukee, Wisconsin

Home self-infusion programs in the treatment of hemophilia have had a definite effect on the blood banking industry. A review of a Wisconsin regional blood center's involvement with the initiation and administration of such a program reveals that the total impact goes beyond mere increased product usage. With appropriate management of program development, staffing, product research, cost analysis, and price negotiation a regional blood center not only can directly alter patient care but also can reduce costs to the patient by as much as 30 percent.

THE DEVELOPMENT of home self-infusion programs as an effective form of replacement therapy revolutionized the care of hemophilia and exerted a significant influence on the blood banking industry. The impact these programs can have on an individual regional blood center is shown by a review of the six-year (1973-1979) involvement of the Blood Center of Southeastern Wisconsin (BCSEW) with such a program in Wisconsin. The present report is an analysis of this impact and a review of the role that a blood center can play in the implementation and subsequent maintenance of a comprehensive hemophilia home care program.

RESULTS. Prior to 1973, almost no patients with hemophilia in Wisconsin were on a home care program. In 1973 a successful home care, self-infusion pilot project was inaugurated by BCSEW. As of May 1979, 104 patients, or 63%, out of the total registered hemophilia A population (165 patients) in Wisconsin are in a standardized home self-infusion program as part of a total hemophilia comprehensive care treatment center program.

Table 1 details the characteristics of the patient population. The classification of severity is based on the plasma factor procoagulant activity: "severe" <1% activity, "moderate" 1 to 5% activity, or "mild" >5% activity. Of the 104 home care patients, 70% (73) are supplied with product directly by BCSEW. Seventy-three of these are in the "severe" or "moderate" categories. The analysis applies to the BCSEW group.

Table 2 details the total annual usage of factor VIII by 65 hemophilia patients. Four patients with hemophilia A and a circulating inhibitor to factor VIII are not included because they utilized factor IX products for therapy.

During 1973 to 1977, there was a marked increase in patient numbers and product utilized, which stabilized in the 1977 to 1979 period. For this reason data from the latter period were selected for analysis. Ten patients used cryoprecipitate exclusively, and four used it intermittently. The 12% reduction in cryoprecipitate utilization from 1977 to 1979 reflects the competitive pricing of commercially produced concentrate and its convenience for ease of administration as compared to cryoprecipitate. While the patient numbers remained stable, overall usage increased by 15% or a little over one-half million units per year. The total of four million factor VIII units used in 1978-1979 represents an average usage of 62,360 units per patient per year, or approximately 18 units per kilogram of body weight per infusion per patient (based on an average number of infusions per year of 55 for this population, whose average weight is 62 kilograms). Only one patient in this group had a surgical procedure (hemorrhoidectomy) during the 1978-1979 period and utilized five additional infusions at home.

In 1979 the hemophilia home self-infusion program product usage represented 87% of the 4.6 million units of factor VIII dispensed by the BCSEW.

This study was supported by DHEW Grant No. MCB-55-001-03, the Faye McBeath Foundation Grant, the Wisconsin Regional Medical Program Project No. 143, and the Great Lakes Hemophilia Foundation, Inc. Research on cryoprecipitate preparation was supported by Grant No. HL 13629 of the National Heart, Lung, and Blood Institute. Part of the data in this study was presented by Ms Lello at the Joint Conference of the American Red Cross and Community Councils of Blood Centers in June 1979. At the time of this study Ms Lello was with the Great Lakes Hemophilia Foundation, Inc, 1701 West Wisconsin Ave, Milwaukee, Wisconsin 53233; Doctor Lazerson was Associate Professor of Pediatrics, The Medical College of Wisconsin, Director of Hemostasis Program at Milwaukee Children's Hospital, and Medical Director of Great Lakes Hemophilia Foundation, Inc; and Mr Krueger is with the Blood Center of Southeastern Wisconsin (formerly Milwaukee Blood Center), 1701 West Wisconsin Ave, Milwaukee, Wisconsin 53233. Publication support provided. Reprint requests to: Jack Lazerson, MD, Department of Pediatrics, University of California at Davis, Sacramento Medical Center, 4301 X Street, Sacramento, California 95817 (phone: 916/453-2779). Copyright 1980 by the State Medical Society of Wisconsin.

Figure 1 illustrates the initial impact of this program on cryoprecipitate production at BCSEW. Prior to the initiation of the program in 1973, total yearly cryoprecipitate usage was 1,500 bags (150,000 units), representing hospital use only. As all the hemophilia A patients placed on this program during 1973-1976 were taught to use cryoprecipitate, usage peaked in 1976 at 14,000 bags (1.4 million units) of which 10,360 bags (1.03 million units) were for home care patients. In 1977 the factor VIII inventory was expanded to include a variety of commercial factor concentrates, reducing cryoprecipitate usage by approximately 50% in 1979.

DISCUSSION. The BCSEW experience clearly demonstrates that the initial and most visible impact that a home self-infusion program can have is in total product usage, as evidenced by the 600% increase in cryoprecipitate usage alone.

When home self-infusion therapy was initiated in Wisconsin, attention was being given by medical and paramedical professionals in hemophilia treatment centers throughout the country to the other problems faced by hemophilia patients, including the availability of therapeutic materials, and the financial and psychosocial problems. Because a new therapeutic modality, aggressive use of replacement therapy, had become available which directly altered lifestyle and lifespans, patients began to experience the other problems associated with a long-term chronic disorder; *eg,* psychosocial, financial, educational, and the like. Consequently, a system of comprehensive

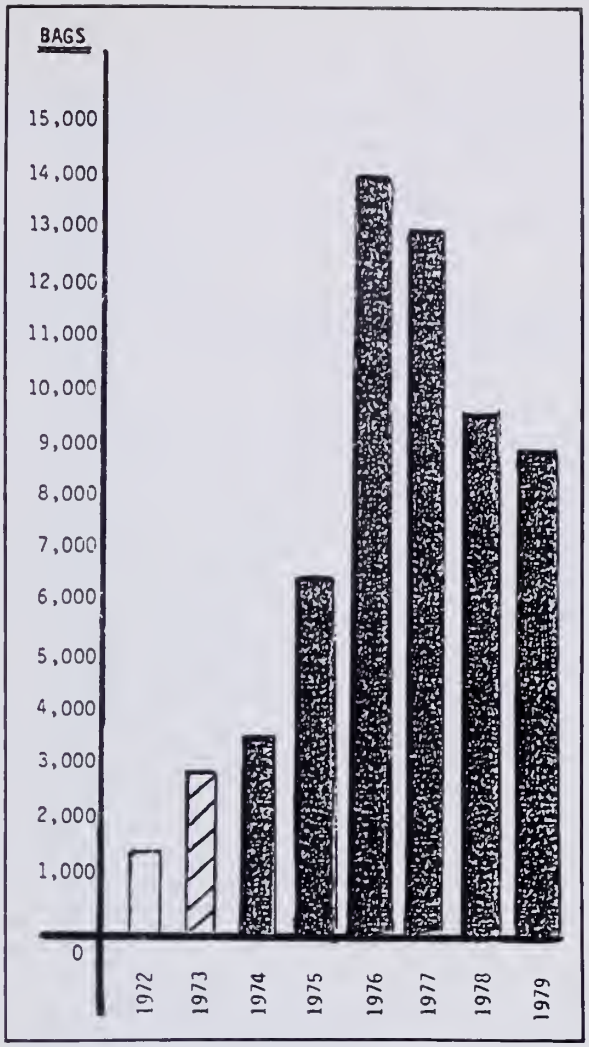

***Figure 1**—Annual cryoprecipitate usage.*

Table 1—Hemophilia home therapy patient demography in Wisconsin

CLASSIFICATION	TREATMENT CENTER *Milwaukee*	*Madison*	*Green Bay*
Severe	40	11	15
Moderate	14	—	6
Mild	15	—	3
Totals (104)	69	11	24

Table 2—Factor VIII home therapy usage for 65 patients

YEAR	CRYOPRECIPITATE	COMMERCIAL CONCENTRATE	TOTALS
1977-1978			
Units	897,600	2,640,515	3,538,115
Percentage	25%	75%	100%
1978-1979			
Units	519,600	3,533,768	4,053,368
Percentage	13%	87%	100%

healthcare developed to address these issues. This system incorporated the full range of services and programs necessary for the proper treatment and long-term care of both the patient's physical disorder and the ancillary needs stemming from and affecting his or her disorder and life.

Sensing this trend and recognizing that an independent coordinating agency was required to administer the "Comprehensive Care" program for hemophilia, BCSEW with the Badger Regional Red Cross Center and other Wisconsin healthcare providers separately incorporated the pilot project in 1974 as the Great Lakes Hemophilia Foundation (GLHF). As a nonprofit, independent healthcare agency, GLHF could administer a hemophilia program for persons with inherited hemorrhagic disorders for Wisconsin without creating the conflicts that sometimes arise when multiple medical facilities and more than one medical school are engaged in a single program.

From this point on there evolved a synthesis of activities for the staffs of both BCSEW and GLHF which represented a departure from the usual position of a blood center in the care of a given patient population. A program of comprehensive healthcare delivery developed in which the blood center directly influenced the quality of healthcare being received by the hemophilia patients. As the number of hemophilia home therapy patients grew and product usage increased and changed, the BCSEW-GLHF model focused on development of a therapeutic product program which was beneficial to the patient and resulted in a more efficient utilization of factor VIII in donated blood.

By maintaining a variety of therapeutic products not only did prices remain reasonable, within market limits, but also product availability was assured. The cost saving to patients is reflected in various ways. In November 1977 one vendor of commercial concentrate increased its charge to 10.5¢ a unit, an average of 2¢ higher than other available products. Using 8.5¢ as an average unit charge, and assuming no change in the use of this product, this increase would have resulted in an annual cost increase of $21,653. The availability of lower priced products enabled patients to avoid this 30% increase by selecting lower priced products.

With the increased use of commercial concentrate, cryoprecipitate usage decreased. However, because of its relatively low cost of production and because factor VIII yield per bag of cryoprecipitate was increased by developmental research, further reducing the cost per unit, continued use by a significant number of patients was justified despite the relative inconvenience in reconstitution and administration of cryoprecipitate.

A preliminary report of BCSEW's successful research in increasing the average units of factor VIII per bag to 120 reduced the cost to the consumer by 1.2 cents per unit. An average annual cost savings per patient of $623 (1978-1979 figures) was realized by the 10 patients who infused with cryoprecipitate exclusively.

Involvement of the blood center in hemophilia care extended to prescription and distribution of product as well. A system was developed permitting careful monitoring of product usage and price. Patients received their product and supplies directly from the blood center, thereby avoiding a pharmacy charge. A prescription form completed by the patient's physician, filed with GLHF, allowed the patient to phone in his order and pick it up in 24 hours.

One final area of concern to the blood center and to the patient is the percentage of coverage by third-party payers. By 1979 the combined efforts of GLHF's Financial Aids Officer and BCSEW's assistant Administrator of Finance, led to 100% coverage either through private insurance or governmental aid of home care therapeutic products and supplies for more than 71% of the patient population served. To aid the remaining 29%, the Wisconsin Legislature passed a bill in 1978 authorizing payment for this group.

As the BCSEW-GLHF experience reveals, the impact a home self-infusion program can have on a regional blood center transcends mere increased product usage. Program development, staff involvement, product research, cost analysis, provision of direct patient care, and price negotiation are intimately related to the overall scope of the program. By such involvement, a blood center can play a significant and direct role in improving the care of patients with hemophilia and other hemorrhagic disorders.

EDITOR'S NOTE: A list of references is available upon request to the authors.

ACKNOWLEDGMENT: The authors wish to thank Richard H Aster, MD, President, Blood Center of Southeastern Wisconsin, for his valuable assistance. ■

Cancer Column

Prepared and supported by the Wisconsin Clinical Cancer Center
in collaboration with the State Medical Society of Wisconsin

ABSTRACT

Adjuvant chemotherapy of breast cancer—consensus statement

A CONFERENCE was held at the National Institutes of Health, July 14-16, 1980 in order to reach general agreement on the concepts, evaluate the results, and determine the implications of adjuvant chemotherapy trials in breast cancer treatment.

Adjuvant chemotherapy of breast cancer means the use of cytotoxic drugs after primary therapy to eradicate occult metastatic disease which otherwise would be fatal eventually. Efficacy must be balanced against toxicity, with the basic measure of therapeutic benefit being patient survival with an acceptable quality of life.

Primary breast cancer is a heterogeneous disease with varying potentials for metastatic relapse and response to adjunctive chemotherapy. Involvement of axillary lymph nodes, menopausal status, and estrogen receptor level are currently believed to be the major critical variables for treatment planning. Lymph node categories thought to be prognostically important predictors of risk of relapse after appropriate local treatment are: negative axillary nodes, one to three positive nodes, and four or more positive nodes.

Merits of a new or modified adjuvant treatment program must be assessed by comparative clinical trials that assign patients randomly to alternative treatments. Patients should be followed for a long enough period; the length depends on the nature of the patient group being studied.

Acute toxicities include bone marrow suppression, nausea, vomiting, loss of appetite, weakness, mouth ulcers, and hair loss. Chronic effects which need to be carefully watched include organ damage such as Adriamycin-induced cardiomyopathy, sterility, or induction of second cancers due to carcinogenic potential of chemotherapeutic drugs used.

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or the State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

A preliminary indication of therapeutic results can be derived from the time the patient is free of disease after treatment. Ultimate efficacy of treatment is measured by survival time, but quality of survival also must be considered. If a study is properly designed and carried out, a negative finding can make an important contribution to knowledge. Results cannot always be anticipated in the original planning, but care must be taken not to be mislead by retrospective observations.

As defined, adjuvant therapy is treatment in addition to adequate surgical therapy. Trials done so far have used radical or modified-radical mastectomy. Future studies may use lesser surgical procedures, but impact of the reduced surgery on adjuvant chemotherapy still must be determined.

Based on these precepts, the panel came to the following consensus on the questions asked:

Have clinical trials established the efficacy of adjuvant chemotherapy of breast cancer? Although positive, encouraging findings have been obtained from clinical trials, the value of adjuvant chemotherapy has only been established with any degree of certainty for premenopausal patients with histologic evidence of lymph node metastasis who have had a mastectomy and increased disease-free and overall survival after adjuvant chemotherapy. Optimal adjuvant therapy for this group has not been achieved, so clinical investigations should be continued. If entry into a well-planned clinical trial is not feasible or acceptable to such patients, adjuvant therapy using an established combination is indicated.

Adjuvant combination chemotherapy with agents active in treating advanced breast cancer is more effective than single agents. Current information suggests that such combinations should be given at full dosage if possible. Postoperative radiotherapy for Stage II disease has not significantly increased survival, but it has reduced chest wall and regional lymph node recurrence in some studies.

Do the benefits of adjuvant chemotherapy outweigh the risks? Survival benefits in premenopausal patients with histologic evidence of lymph node metastases (Stage II) seem to outweigh the disadvantages of early toxicity. Psychosocial problems of giving repeated courses of adjuvant

chemotherapy have not been quantitatively defined and should be investigated.

Should future adjuvant studies include hormonal manipulations? Previous studies using hormonal manipulation have been suggestive but not definitive regarding increased survival. Studies of estrogen receptors are yielding more reliable data, but no hormonal manipulation has yet been established with enough confidence to make hormonal alterations with or without chemotherapy a standard form of adjuvant therapy. Estrogen receptor activity should be routinely measured quantitatively in all patients.

What is the role of adjuvant chemotherapy in Stage I breast cancer patients? Patients with histopathologically negative axillary nodes usually have a good prognosis after appropriate local therapy—80% have a five year disease-free survival without adjuvant chemotherapy. Use of adjuvant chemotherapy in this group may expose the majority of patients to risk of toxicity without benefit. No conclusive data from clinical studies exist to support the routine use of adjuvant chemotherapy in this group.

What is the role of adjuvant chemotherapy in postmenopausal patients? Some recent studies indicate early benefit in disease-free survival in subsets of postmenopausal patients. The preliminary nature of this information precludes a definitive statement about the role of such treatment. Broad acceptance of the results of such trials would require an untreated concurrent control group. Postmenopausal women with estrogen receptor positive tumors may benefit from administration of relatively nontoxic hormonal treatment; however, it may be necessary to give multiple drugs at full dose to obtain clinical benefit.

Adjuvant chemotherapy of breast cancer is a rapdily changing field, so it is important that both physicians and patients realize that definitive answers do not exist for the best management of all aspects of this complex disease. Decision-making and treatment should be multidisciplinary. Administration of chemotherapy should be undertaken only by or under the supervision of a physician experienced in their use. There must be frank open communication between the physician and patient about possible treatment options and variables which determine the patient's probable prognosis for risk of relapse and response to therapy.—Abstracted by **Dorothy J Buchanan-Davidson, PhD,** Science Writer ■

NEWS YOU CAN USE

ALERT TO PHYSICIANS. An organization calling itself the "American Medical Society" and using a return address of 416 North Main Street, Fond du Lac, Wisconsin, is sending statements to MDs in the Midwest for $120 contributions. Although contact has been made with a partner of the person who operates the Society, he refuses to identify his associate. All efforts to contact the "American Medical Society" have failed or been rebuffed.

ACS GREAT AMERICAN SMOKEOUT ENCOURAGES SMOKERS TO QUIT. The American Cancer Society's annual Great American Smokeout will be November 20. The Great American Smokeout is a national effort to encourage smokers to quit for one day, perhaps leading them to try to quit for a longer period. Posters, pledge cards, payroll stuffers and various other promotional ideas are available from the local chapters and state office of The American Cancer Society. Information may be obtained by writing or calling: The American Cancer Society, 611 N Sherman Ave, Madison, Wis 53704; phone 608/249-0487.

RADIATION SURVEY TO ASSESS WOMEN'S HEALTH. The National Center for Health Statistics this summer began conducting a National Radiation Survey. Its purpose is to assess the health of women of childbearing age and to determine the extent of therapeutic and/or diagnostic x-ray, ultrasound, and nuclear medicine these women received in 1979 and 1980. Questionnaires, sent to a sample of about 14,000 women, cover many health-related topics. ■

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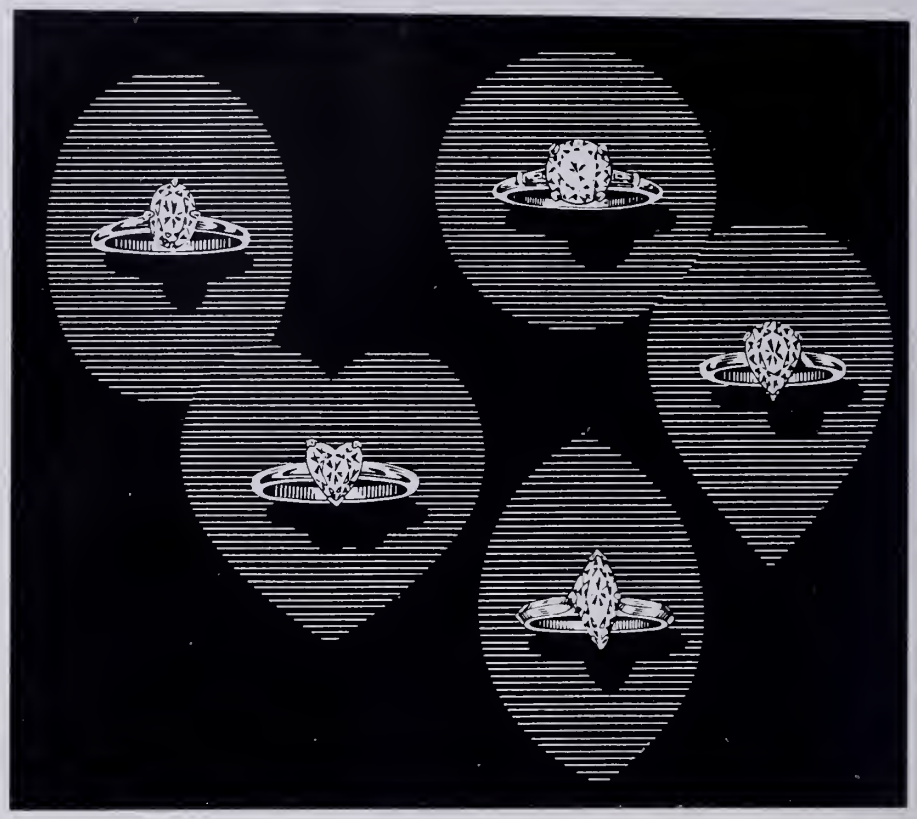

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SMS states position on 4.4% budget cut

SMS President Russell F Lewis, MD, Marshfield, on October 1 presented Don Percy, secretary of the Dept of Health and Social Services, with the Society's position regarding the 4.4% budget cut in the State's Medicaid program and its impact on physician providers.

In a meeting between SMS officers and staff and DHSS representatives, Doctor Lewis told Secretary Percy that the most acceptable method for recovering the 4.4%, or $1.7 million which applies to physicians' services in the Title 19 program, would be to delay the anticipated 8% increase in physician reimbursement until approximately January 1, 1981. According to individual provider agreements, this increase was supposed to have taken effect on July 1, 1980.

During the meeting Doctor Lewis stressed that the Society's major concern was not with the current 4.4% budget cut but with the ability of the Medicaid program to meet costs during the 1981-83 biennium.

He stressed that unless a critical review is undertaken of the current efficiency of the program, it would continue to experience revenue shortfalls in the future.

Obviously pleased with the Society's position, Secretary Percy agreed with the Society's assessment and proposed resolution to the immediate 4.4% cutback for physician reimbursement and said it was a more reasonable approach than that taken by other provider gorups.

The letter Doctor Lewis gave DHSS Secretary Percy at the October 1 meeting follows:

"The State Medical Society of Wisconsin has given thoughtful consideration to the chain reaction set in motion by the current revenue shortfall in Wisconsin and the resulting general revenue budget cuts of 4.4%. The impact upon Medicaid, the third largest state expenditure program, is substantial and the response of the state has been a reduction in payments to all health care providers. The Society is fully aware that the only options available are such reductions or changes in the benefit package offered by the medical assistance program. The latter course requires legislative approval.

"Specifically, it has been proposed that 1980-81 spending for Medicaid services be reduced by approximately $35-40 million. Of this reduction, as much as $1.7 million may be applied to physicians' services. The state has annual agreements with individual physicians participating in the Medicaid program which call for services under Medicaid to be paid at a rate which correlates to payments made in the Medicare program. The Medicare rate of reimbursement to physicians increased on July 1 of this year by about 8%, an increase approved by the federal government.

"In consideration of the deteriorating condition of the state budget and the continuing needs of the poor for necessary medical care, the State Medical Society proposes that the Department delay until January 1, 1981, implementation of the maximum allowable 8% increase in physician reimbursement, an increase which according to the individual provider agreements should have taken effect on July 1 of this year. We believe that this course of action is reasonable and responsible, and will avoid irreparable damage to the basis for physician reimbursement in Medicaid; namely, the Medicare profile system. A continuance of physician reimbursement at the present rate for the six month period of July 1 to December 31, 1980, will save Wisconsin taxpayers approximately $1.7 million.

"At the same time, the Society urges the Department, the Governor, and the Legislature to work with physicians, other providers, and the public to seriously review and revise the medical assistance program to make it more compatible with the state's ability to pay and the recipient's need for health care services. We believe that no stone should be left unturned in this effort and that of necessity eligibility standards, the scope of benefits, and administrative efficiency be critically examined. As Medicaid approaches $1 BILLION by 1983, only this type of review and revision will avoid crisis management of the Medicaid budget in upcoming years.

"It is important to remember the Society was the only major provider group which openly supported the efforts of the Governor and the Department in early 1979 to reexamine the benefit levels of the Medicaid program as there were signs that Medicaid costs were rising faster than available revenues. To our knowledge it is the only provider group that has accepted a delay in reimbursement to help the state overcome its fiscal crisis.

"The Medicaid program has been identified by many as a "Cadillac" program when state revenues suggest that a "Chevrolet" is more appropriate. The Society believes that the time has come for the rhetoric to end. The Society is prepared over the remaining months of this year to offer its recommendations on the scope of Medicaid benefits, the overuse of services by both recipients and providers, equitable provider reimbursement, administrative changes to reduce costs associated with claims and overhead, and cost consciousness in the provision of medical services.

"We believe that a more responsible but continuingly humane and compassionate Medicaid program will result from such a review. This will succeed only if all parties, including the Governor and the Legislature, join in that effort."

The Society's position was approved by the Council at its September 27 meeting. ■

Medical students discuss impairment problem

"According to current estimates, 15% of you in this room will become alcohol, drug, or mentally impaired at one time or another in your lives," Gerald Kempthorne, MD, Spring Green, told first and second year medical students during a noon lecture at the University of Wisconsin Medical School September 10.

Doctor Kempthorne, chairman of the Impaired Physician Program of the State Medical Society of Wisconsin, explained the State Medical Society's program for helping the impaired physician and urged the medical students to do the same with their classmates.

"I am convinced that you complete your medical school training as a basic idealist," he said, "it is only with time that some of you will evolve into an impaired physician."

Why the change? Doctor Kempthorne said this wasn't known yet, and until we can discover what it is that makes physicians change and until an effective prevention and educational methodology is arrived at, we must concentrate on identifying these physicians with problems and helping them overcome their handicaps.

"We have the loftiest calling of any profession—we dedicate ourselves to serving the needs of our patients," he said. "There is no way we can condone impairment which interferes with that calling."

In closing, Doctor Kempthorne offered a word of advice to the aspiring physicians in the audience: "In your career avoid being placed upon a throne, and thereby avoid the omnipotence and stress associated with impairment problems. Remember, you are human and you have the same frailties as non-MDs." ■

Washington County Jail earns accreditation

SMS Jail Health Care Coordinator Parks Reinhardt reports that the Washington County Jail has received a two-year accreditation from the State Medical Society-American Medical Association's Jail Health Care Program. In order to become accredited a jail must comply with 23 essential healthcare delivery standards and 85% of the remaining 46 standards. Furthermore, three new county jails—LaFayette, Douglas, and Marinette, have recently joined the program, bringing the number of participating Wisconsin jails to 30. ■

CME accreditation site surveyors needed

The Society's Commission on Continuing Medical Education, through its Subcommittee on Accreditation, is seeking additional surveyors for site visits to accredit hospital, specialty society, and county society continuing medical education programs.

According to Commission chairman, George A Berglund, MD, Milwaukee, there are no special qualifications or limitations for physicians who wish to serve; there is no age barrier, and all specialties and any degree of involvement are acceptable. Physicians may serve as little as once a year or as many times as they wish. Physicians unfamiliar with the site surveys will accompany experienced surveyors three or four times before being asked to write a report, Doctor Berglund noted.

Since 1974 the Society's accreditation program surveyors have reviewed 101 hospital, 50 specialty society, and 4 county medical society CME programs. Currently the State Medical Society and the American Medical Association have accredited 47 hospitals and 27 specialty societies, and 1 county medical society.

If any member is interested in participating in site survey visits, contact SMS offices in Madison: Arlene Meyer or Bill Wendle at 608/257-6781 or toll-free 1-800-362-9080. ■

CES FOUNDATION

CONTRIBUTIONS—AUGUST 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1980.

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A "thank you" to CME site surveyors

The SMS Commission on Continuing Medical Education wishes to thank its Subcommittee on Accreditation and the 60 surveyors who have completed at least one site survey during the period December 1974 through mid-July 1980. Six of the surveyors have completed 10 or more surveys.

Surveyors are listed below in alphabetical order, with those having done 10 or more surveys noted with an asterisk and those who are members of the Subcommittee on Accreditation noted with (SOA).

Richard D Adelman, MD, Oshkosh
John R Allen, MD, Wausau
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Jerold J Beerends, MD, West Bend (SOA)
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David C Reynolds, Madison
Benson L Richardson, MD, Green Bay
*Richard D Sautter, MD, Marshfield (SOA)
Weldon D Shelp, MD, Madison
Frank A Springer, MD, Menomonie
Paul C Tracy, MD, Madison
James J Tydrich, MD, Richland Center
Philip H Utz, MD, LaCrosse
Sherman P Vinograd, MD, Madison
Harold Wagner, MD, Kenosha
Walter Washburn, Madison
Warren K Wright, MD, Chippewa Falls
Ed Zupanc, MD, Monroe

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Decertification rule protest lodged with DHSS

A statement of protest concerning the latest draft of decertification rules for the review of open heart surgical and cardiac catheterization services was endorsed by a vote of 22 to 2 by a state-appointed technical advisory committee in September.

The committee, consisting of physicians and other healthcare professionals, sent a letter to Dept of Health and Social Services Secretary Donald Percy stating that the rules in their present form do not accurately reflect the quality and cost efficiency of open heart surgery and cardiac catheterization programs in the state. The committee disagreed with the DHSS's use of excess capacity and current utilization rates—and not quality, as the first consideration in deciding whether to decertify a program.

Finally, the committee stressed it would "never endorse any regulatory mechanism which replaces the professional judgment of physicians acting in a peer review capacity with nonprofessional attempts at assessing quality of medical care for the people of Wisconsin."

The SMS Health Planning Commission has recommended that the draft administrative rules be substantially revised to reflect the intent and authority of the Wisconsin Legislature before being sent to it for review. The DHSS has stated that it intends to present the rule to the Legislature by October 15. No response had been received from Secretary Percy's office by October 1. ■

Support given to health insurance risk-sharing plan for uninsurables

Broad-based support was voiced from the insurance industry and consumer groups for administrative rules implementing the mandatory health insurance risk-sharing plan passed by the Legislature in the recently concluded session. Rules for the plan were discussed at a September 16 hearing held by the Commissioner of Insurance in Madison.

SMS initiated the legislative push for protection for "uninsurables" back in 1973 and supported the bill that finally passed in 1980.

The plan is to provide health insurance for uninsurable residents of Wisconsin. Eligibility criteria established by the proposed rules require that a person applying for coverage by the plan must have: 1) a notice of rejection or cancellation from two or more health insurers; or 2) a notice of substantial reduction or limitation of coverage from a health insurer when compared to a person of standard risk with similar coverage; or 3) a notice of a 50% or more increase in premium unless the increase applies to all of the insurer's health insurance policies; or 4) a notice of premiums for a policy not yet in effect from two or more insurers which exceeds the premium applicable to a person who is standard risk by 50% or more.

The plan is to offer Major Medical type coverage for persons not eligible for Medicare or Medicaid. There will be a $1,000 deductible for Major Medical and a 20% coinsurance up to a yearly out-of-pocket ceiling of $1,500 per individual and $3,000 per family. There is a lifetime limit of $250,000 per covered individual.

The proposed rules must yet go to the Legislature and the program is not expected to be operational before the beginning of 1981. ■

1980-81 Membership Roster to be published in January

After an eight-year absence a listing of the State Medical Society members will appear in the January 1981 issue of the *Wisconsin Medical Jouranl.*

The Council, at its September 27 meeting, approved publication of a Membership Roster which will be presented alphabetically by county medical society. A separate reference section will be included, listing each city in which one or more physicians practice, and that listing will cross reference to the location of each county society listing.

The roster will include the member's name, address, telephone number, and specialty. With exception of the phone number, the information will be provided to WMJ from the current membership computer program. All members will be receiving a self-contained returnable form to confirm the member's address and specialty, and a space for listing the telephone number.

To contain costs the WMJ will not include other editorial matter in the roster issue. Because of the nature of the issue additional advertising space will be offered to medical clinics, hospitals, and other patient care services.

The Membership Roster will include all members of record on November 15, 1980. (Those members who have not paid any of their 1980 dues are being removed from membership on October 15.)

Members are urged to watch for the Membership Roster communication, check it over, write down the telephone number, and return it to the SMS as soon as possible. ■

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of September 3, 1980

NEW MEMBERS

County Medical Society

DOOR-KEWAUNEE

Wenngatz, Halbert F, 1304 First St, Kewaunee 54216 (1950, Regular, Family Physician, Certified)

GREEN

Vickerman, Robert L, 2106 19th Ave, Monroe 53566 (1942, Regular, Obstetrics and Gynecology, Certified)

LACROSSE

Wilkes, Shelby R, 2630 S 7th St, LaCrosse 54601 (1950, Regular, Ophthalmology)

MILWAUKEE

Bock, Harvey M, 606 W Wisconsin Ave, Suite 1706, Milwaukee 53203 (1946, Regular, Plastic Surgery/General Surgery, Certified-PS)
Choithani, Hansa C, 4778 N Cramer St, Whitefish Bay 53211 (1931, Regular, Obstetrics and Gynecology, Certified)
Dagon, Eugene M, 5851 North Shore Dr, Whitefish Bay 53217 (1939, Regular, Psychiatry Neurology, Certified)
Deshur, William, 425 E Wisconsin Ave, Suite 218, Milwaukee 53202 (1948 Regular, General Surgery/Cardiovascular Surgery)
Fetherston, Michael P, 6900 North Port Washington Rd, Milwaukee 53217 (1950, Regular, Family Physician)
Gogan, Robert J, 10520 North Port Washington Rd, Mequon 53092 (1949, Regular, Otorhinolaryngology/Plastic Surgery)
Harris, Gerald J, 8700 W Wisconsin Ave, Milwaukee 53226 (1944, Regular, Ophthalmology, Certified)
Hart, Ronald D, 161 W Wisconsin Ave, Suite 4140, Milwaukee 53203 (1950, Regular, Oncology/Internal Medicine, Certified-IM)
Lipoff, Jay I, 2040 W Wisconsin Ave, Milwaukee 53233 (1950, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)
Mattingly, Richard F, 8700 W Wisconsin Ave, Milwaukee 53226 (1925, Regular, Obstetrics and Gynecology)
Melzer, Daryl J, 3070 North 51st St, Suite 411, Milwaukee 53210 (1951, Regular, Internal Medicine)
Norris, Arthur G, 1220 Dewey St, Milwaukee 53213 (1937, Regular, Psychiatry)
Panagis, Constantine, 841 North Broadway, Milwaukee 53202 (1922, Regular, Internal Medicine, Certified)
Pulito, Domenic J, 7545 North Port Washington Rd, Milwaukee 53217 (1950, Regular, Orthopedic Surgery)
Wartenberg, Alan A, 10243 W National Ave, West Allis 53227 (1947, Regular, Internal Medicine)
Wojno, Ted, 2310 North 95th St, Apt 3, Wauwatosa 53226 (1952, Resident, Ophthalmology)

PORTAGE

Boehm, Frederick J II, 122 N Wilshire Dr, Stevens Point 54481 (1951, Regular, Obstetrics and Gynecology)
Dunlap, Roy J II, 508 Vincent St, Stevens Point 54681 (1946, Regular, Otorhinolaryngology, Certified-OTO)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Fulks, Michael W, Madison, to 2214 Peters Dr, Apt 322, Eau Claire 54701
Rice, Maurice G, Madison, to Plover 54467

EAU CLAIRE-DUNN-PEPIN

Koch, Edgar L, Eau Claire, to 6308 8th Ave, Kenosha 53140

LACROSSE

Boland, Terrence W, Spring Grove, MN, to 16th Ave, South, Onalaska 54650
Johnson, Gordon L, LaCrosse, to 6630 Hillridge Dr, Greendale 53129
Park, Tai J, LaCrosse, to 130 Second St, Neenah 54956

OUTAGAMIE

Cronkhite, John I, Appleton, to 217 Rusgan Dr, Bloomington, IN 47401

ROCK

Glesne, Orvin G, Lakeview, AR, to Rt 3, Box 166, Miltona, MN 56354

DEATHS

Jones, Weston W, Columbia-Marquette-Adams County, Mar 8, 1980
Behnke, Charles H, Winnebago County, Aug 2, 1980
Lambert, Joseph W, Langlade County, Aug 10, 1980
Thayer, Richard A, Rock County, Aug 26, 1980
Wilets, Jack B, Milwaukee County, Aug 27, 1980 ■

Obituaries

◊County, State, AMA Members

◊ **Weston W Jones, MD,** 66, Portage, died Mar 8, 1980 in Portage. Born June 8, 1913 in Sparta, Doctor Jones graduated from Northwestern University Medical School in 1939. His internship and residency were served at Evanston Hospital, Evanston, Ill, and Minneapolis General Hospital in Minneapolis, Minn. During World War II, he served in the United States Army Air Corps. He was a former chief-of-staff of Divine Savior Hospital in Portage, and also served as president of the Tri-County Medical Society. Surviving are his widow, Nita; one son, William, Bloomington, Ind; four daughters, Mrs Peter (Robin) Doyle, Fond du Lac; Mrs. James (Judith) Hamele, Rhinelander; Mrs Jack (Nancy) Schaper, Portage, and Mrs J (Susan) Mathis, Irvine, Calif; two stepdaughters, Mrs John (Colleen) Hepler, Portage, and Judy Grove of Madison.

◊ **Joseph W Lambert, MD,** 83, former Antigo physician, died Aug 10, 1980 in Eveleth, Minn. Born Apr 29, 1897 in Des Plaines, Ill, Doctor Lambert graduated from Northwestern University Medical School in 1923 and served his internship at Cook County Hospital in Chicago. He served as a 13th District Councilor of the State Medical Society of Wisconsin from 1938-1942. Doctor Lambert served in the United States Army Medical Corps during World War II from 1942-1945. He was a member of the "50 Year Club" of the State Medical Society. Surviving are two daughters, Mary Kay and Anne of Milwaukee; a stepdaughter, Mrs Raymond (Mary) Debevec, Eveleth, Minn; and a stepson, James Sullivan of Dark Lake, Minn.

◊ **Richard A Thayer, MD,** 73, Beloit, died Aug 26, 1980 in Beloit. Born Nov 1, 1906 in Beloit, Doctor Thayer graduated from Northwestern University School of Medicine in 1933 and served his internship at Wesley Memorial Hospital in Chicago. Doctor Thayer served as city health officer of Beloit and also served with the United States Army Medical Corps from 1942-1946. He began his medical practice in Beloit in 1934 and at one time was director of the Intensive Care Unit of Beloit Memorial Hospital. Surviving are one stepdaughter, Mrs Harold (Jeanne) Tower, Beloit; and three stepsons, John, Joseph, and Michael McCarthy. ■

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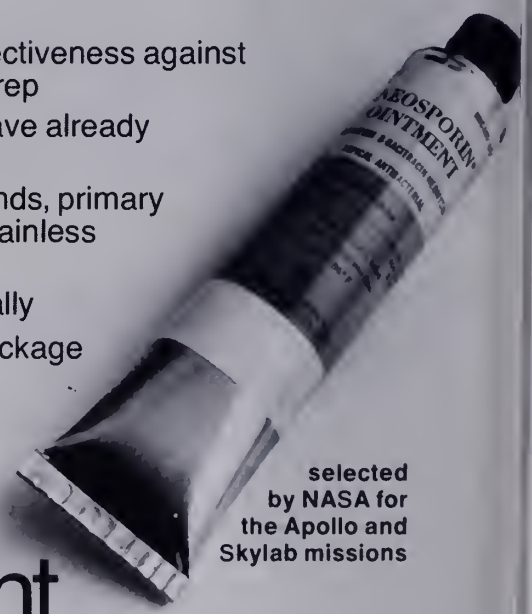

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptib organisms, including fungi. Appropriate measures shou be taken if this occurs.

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County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Professional societies work together to improve health care of Dane County residents

David W Semian, MD,* President-elect
Dane County Medical Society
Madison, Wisconsin

IN MID-MAY the Dane County Medical Society and the Dane County Pharmaceutical Society began to distribute the "Medication Card" to county physicians and pharmacists.

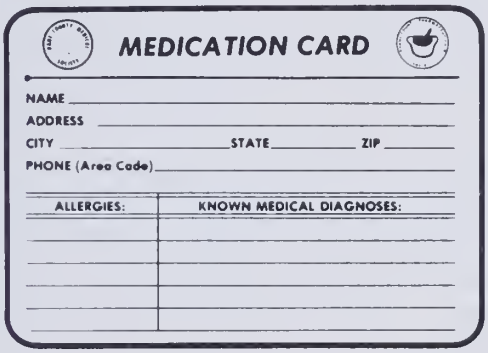
The Medication Card is a billfold size, trifold card which the patient can carry to convey important medical and drug usage information. One side of the Card contains information about the patient: name, address, individual to notify in the event of an emergency, allergies, known medical diagnoses, and phone numbers of the patient's personal physician and pharmacist. The opposite side of the Card lists prescription and over-the-counter drugs currently taken. The Medication Card's bright orange color is easily seen and hopefully will lead to prompt treatment in time of emergency.

The Medication Card Project was developed in an effort to improve the health care of Dane County residents, especially those taking multiple medications. At the same time it is hoped that the use of the Card will improve communication among physicians, pharmacists, and patients; and that patients will begin to take a more active part in their own health care.

Participation in this Project is voluntary on the part of the physician, pharmacist, and patient. The Medication Card, which is free to the patient, is paid for by the Dane County Medical Society. To date 30,000 cards have been printed.

A Medication Card Packet, consisting of 50 Medication Cards, a holder for displaying the Medication Cards, assembly instructions for the Card holder, and information on how the Cards are to be used were distributed to all Dane County Medical Society members. Physicians and pharmacists are encouraged to keep the Cards displayed in patient areas, make appropriate entries on the Cards, and encourage Card usage. Undoubtedly the success of the Medication Card Project depends upon a team effort; however, its success was greatly enhanced when the Dane County Pharmacists agreed to complete the Card whenever a patient presents a prescription. To date the Medication Card has been well received. The news media have been very helpful in alloting time for this Project on radio, television, and in local newspapers.

If any additional information is desired, contact the Board of Trustees, Dane County Medical Society, Post Office Box 1109, Madison, Wisconsin 53701.


MEDICATION CARD

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE (Area Code) _____

ALLERGIES:	KNOWN MEDICAL DIAGNOSES:

PIERCE-ST CROIX: The office of Dr Frank W Epley, former New Richmond physician, has been restored at the Fort Crawford Medical Museum in Prairie du Chien through contributions from members of the Pierce-St Croix County Medical Society.

Doctor Epley practiced in New Richmond from 1877 until his death in 1908. He was one of three related physicians who made early medical history in northwestern Wisconsin.

Doctor Frank W Epley was the first physician in the Minnesota-Wisconsin area to do blood transfusions. His "case book," dated 1879 and describing a transfusion to Mrs H L Bixby of Star Prairie, is on display in the museum.

Doctor Frank Epley's father-in-law was Doctor Otis Hoyt who served in both the civil and Mexican wars before coming to Wisconsin to practice first in St Croix Falls, then Hudson, and finally Stillwater, Minnesota. Doctor Frank Epley's son was Dr Otis Hoyt Epley who practiced in Baldwin and New Richmond until his death in 1974.

The Museum at Prairie du Chien is open to the public 10 am to 5 pm daily from May 1 to October 31. ■

Specialty Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Wisconsin Society of Internal Medicine conducted its annual meeting and scientific program September 11-13 at Merrimac. Kenneth I Gold, MD,* Beloit, was installed as president for the year 1980-81. Doctor Gold served as secretary-treasurer in 1978-79 and as president-elect last year. He was elected to the governing council in 1977. He currently is a delegate to the American Society of Internal Medicine. In concurrent action, Russell A Quirk, MD,* Racine, was named president-elect.

Others elected were: MDs Joseph J Mazza, MD,* Marshfield, secretary-treasurer; Philip J Dougherty,* Menomonee Falls, Charles S Geiger Jr,* West Bend, and Edwin Overholt,* LaCrosse, to three-year terms on the governing council. Elected to two-year terms were: MDs James R Mattson,* Green Bay, and James A Means* of Milwaukee. Thomas P Driscoll, MD,* Wauwatosa, was elected to a one-year term. As outgoing president, Michael J Mally, MD,* Hartford, will continue as a council member along with Anthony P Ziebert, MD,* Milwaukee. Serving as an ex-officio member of the council is Charles L Junkerman, MD,* Milwaukee, who is the American College of Physicians' governor for Wisconsin.

Wisconsin Academy of Family Physicians, meeting in Wisconsin Dells earlier this year, through its Congress of Delegates, unanimously endorsed a resolution offering to assist the State Medical Examining Board and other peer review groups in dealing with impaired or disabled physicians and physicians accused of practice irregularities.

In a companion resolution, the delegates asked their own membership committee to review the membership status of any member who is reviewed by the Medicare Review Committee, has his license suspended by the Medical Examining Board, is identified as impaired by the State Medical Society, has his hospital privileges suspended for actions related to personal behavior or patient care, is the subject of legitimate patient complaints brought before the State Medical Society or the Academy, or is convicted of a felonious act.

The Wisconsin Academy is an organization of 1300 family physicians and residents in family practice training programs in Wisconsin.

The delegates at the 32nd annual meeting also asked the Academy's Long Range Planning Committee to investigate the feasibility of establishing an Independent Practice Association (IPA), which could provide prepaid medical care with family physicians and other primary care physicians as the principal provider.

Charles Steidinger, MD,* Platteville, was elected president-elect of the Academy. He will take office as president next June, succeeding John O Grade, MD,* Elm Grove, who was installed at this year's meeting. Jack Strong, MD,* Mauston, was elected secretary-treasurer. William Wright, MD,* Mondovi, was elected speaker of the Congress of Delegates, and Thomas H Peterson, MD,* Wausau, was elected vice speaker.

Newly elected to the Board of Directors were MDs Julio DeArteaga,* Brillion, and Arne T Lagus,* St Croix Falls.

During the annual meeting the Academy presented Norbert G Bauch, MD* of Milwaukee with its first "Special Service Award" for outstanding service to the Academy and to the specialty of family medicine. Doctor Bauch founded the first Family Practice Residency Program at St Michael Hospital in Milwaukee in 1971. He remains head of that program today.

The Academy also honored John H Renner, MD,* former chairman of the Department of Family Medicine and Practice at the University of Wisconsin Medical School, a program which he established in 1974. Doctor Renner has recently left the state for a new position in Missouri. ■

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Lynn Koob, MD, Rice Lake, recently joined the medical staff of the Lakeview Medical Center as a general surgeon. Doctor Koob graduated from the University of Iowa Medical School and served his general internship with the Gundersen Clinic at LaCrosse. Prior to moving to Rice Lake, Doctor Koob had been a general surgeon on the medical staff of Luther Hospital in LaCrosse. He also is affiliated in practice with the Indianhead Medical Group.

Craig S Ajdukovich, MD, recently joined the medical staff of the Edgerton Clinic. He graduated from the University of Wisconsin Medical School, Madison, and completed his internal medicine residency at the University of Massachusetts Medical Center.

James J O'Connor, MD, recently became a member of the Marshfield Clinic medical staff in the Department of Orthopedic Surgery. Doctor O'Connor graduated from Georgetown University Medical School, Washington, DC, and served his internship and residency training at Dartmouth-Hitchcock Medical Center in Hanover, NH. He also had residency training at Newington Childrens Hospital, Newington, Conn.

Roger Cady, MD, Hillsboro, recently joined the medical staff of the Hillsboro Clinic and is associated with Larry Boehme, MD.* Doctor Cady graduated from Mayo Medical School, Rochester, Minn, and completed his family practice residency program at St Francis Medical Center, LaCrosse.

James Icken, MD, recently became associated with the clinic adjacent to the Columbus Community Hospital. Doctor Icken graduated from the University of Vermont Medical School and completed his family practice residency at the University of Iowa at Iowa City. He served in the United States Navy for two years prior to moving to Columbus.

Anup Chakraborty, MD, Tomah, recently joined the medical staff of the Tomah Veterans Adminstration Medical Center as director of the respiratory care unit and as acting chief of the medical service. A native of India, he graduated from the University of Calcutta Medical School. His residency was served at the Brooklyn VA Medical Center and the Downstate University Medical Center. He also was a fellow in pulmonary medicine at the National Jewish Hospital and Research Center and the University of Colorado Medical Center. Doctor Chakraborty was on the medical staff of the Denver VA Medical Center and also served on the Colorado University Medical Center faculty while in Denver.

Jed Maker, MD, and **Pam Bamrah, MD,** recently joined the medical staff of the Wilkinson Clinic in Oconomowoc. Doctor Maker, an obstetrician and gynecologist, graduated from the University of Vermont Medical School, Burlington, Vt, and completed his residency at the University of Wisconsin Medical School, Madison. Doctor Bamrah graduated from Rajendra Medical College, Penjab University, Patiala, India. She served her family practice residency at Deaconess Hospital and the Medical College of Wisconsin in Milwaukee. Her husband, Virinderjit Bamrah, MD, is a cardiologist associated with the VA Hospital, at Wood, and the Medical College of Wisconsin.

Mark Rholl, MD, Cameron, recently became associated with James L Esswein, MD, at the Cameron Medical Clinic. He graduated from the University of Minnesota Medical School where he also completed his residency in family practice.

Rick R Reding, MD, Kroenenwetter, recently joined the medical staff of the Stahmer Clinic S C in Wausau. Doctor Reding graduated from the Medical College of Wisconsin in 1977. He completed his residency training, in internal medicine, at the Milwaukee County Medical Complex Affiliated hospitals.

David E Westgard, MD,* LaCrosse, a family practitioner at Skemp-Grandview-LaCrosse Clinic, recently was appointed Clinical Assistant Professor of Family Medicine and Practice at the University of Wisconsin, Madison, Center for Health Sciences. Doctor Westgard is a member of the Board of Directors of the Western Wisconsin Health Systems Agency and also is a member of the Commission on Mediation and Peer Review of the State Medical Society of Wisconsin.

David Olson, MD, New Richmond, recently joined the medical staff of the New Richmond Clinic. Doctor Olson graduated from the University of Wisconsin Medical School, Madison, where he also completed his family practice residency program.

Jeffrey A Kurtz, MD,* Wausau, recently opened his medical practice in the Physicians Office Building at Wausau Hospital Center. A plastic surgeon, Doctor Kurtz graduated from Creighton University Medical School. He served a one-year surgical internship, five-year general surgical residency, and a two-year plastic and reconstructive surgery residency at the University of Wisconsin Hospitals in Madison.

Donn Fuhrmann, MD,* New London, recently opened his medical practice with Carlos Yu, MD,* at the new Medical Associates of New London, SC, building. Doctor Fuhrmann graduated from the University of Wisconsin Medical School, Madison, followed by an internship at University Hospitals, Madison, and a family practice residency at St Luke's Hospital, Milwaukee.

Vera Slavic-Svircev, MD,* Middleton, recently was certified as a diplomate of the American Board of Anesthesiology. A graduate from the University of Novi Sad School of Medicine, Yugoslavia, Doctor Slavic-Svircev completed her residency in anesthesiology at the University of Wisconsin Hospital and Clinics, Madison.

Leland C Pomainville, MD,* Wisconsin Rapids physician for nearly 50 years, recently received the award from the Modern Woodmen of America Camp 1358, in recognition of his leadership and involvement in the community. Doctor Pomainville was one of the founders of the South Wood County Historical Society Museum in 1955 and served as its first president. He is the historian of the State Medical Society of Wisconsin and also serves as treasurer of the Charitable, Educational, and Scientific Foundation of the Society.

Bruce Herman, MD, Brown Deer, has opened his medical practice at the Mequon-Thiensville Medical Center. He is director of the Clinic and is a graduate of the Medical College of Wisconsin, Milwaukee. He served an internship at Montefiore Hospital in Pittsburgh, Pa, and completed his residency in internal medicine at Mount Sinai Medical Center, Milwaukee.

Alan Taber, MD, Berlin, recently joined the medical staff of the Berlin Physicians Clinic. He is associated with MDs Michael Tieman,* Richard Gubitz, and William Piotrowski. Doctor Taber graduated from Northwestern University Medical School, Chicago and completed his internship at Grant Hospital, Chicago, and his residency at St John's Hospital at the University of Minnesota.

Ross A Abrams, MD, recently was appointed assistant professor of medicine in the section of hematology/oncology at the Medical College of Wisconsin. He comes to Milwaukee from the National Cancer Institute (NCI) in Bethesda, Md. He had been with NCI for four years, most recently as staff associate in the radiation oncology branch. Doctor Abrams graduated from the University of Pennsylvania School of Medicine in 1973. In 1975 he received an American Cancer Society fellowship for clinical training in hematology and oncology at the University of Pennsylvania School of Medicine.

Arne T Lagus, MD,* St Croix Falls, recently was appointed to the board of directors for the Wisconsin Academy of Family Physicians. Doctor Lagus has been a member of the academy for 12 years and will serve on the 10-member board for three years.

Frank J Cadwell, MD, Ashland, has been appointed to the medical staff of Memorial Medical Center. A graduate from the University of Minnesota Medical School, he completed his internship and residency at Northwestern Hospital in Minneapolis.

Richard N Foltz, MD, Rhinelander, recently became associated with Robert H Kitzman, MD,* in the practice of orthopedic surgery. A Minocqua native, Doctor Foltz graduated from the University of Wisconsin Medical School and served an internship in general medicine and surgery at Presbyterian Medical Center, Denver, Colo. His residency in orthopedic surgery was taken at University of Wisconsin Hospitals, Madison, where he also was chief resident. Since 1976 he has been chief of the Emergency Room Department at Methodist Hospital in Madison.

Reuben J Adams, MD, internal medicine specialist, has joined the Gundersen Clinic medical staff at its branch clinic in Whitehall. He graduated from the University of Wisconsin-Madison, and served his residency at LaCrosse Luthern Hospital. Since 1978 he has been chief of internal medicine at Mountain Home Air Force Base, Idaho.

Stanley L Inhorn, MD,* Madison, received the 1980 Basic Prevention Award of the Wisconsin Public Health Association (WPHA) at its recent annual conference. The WPHA stated that "through his research, his teaching, and his service, Doctor Inhorn has contributed immensely to the prevention of disease and disability among Wisconsin people." Doctor Inhorn has been associated with the University of Wisconsin Medical School and the Wisconsin State Laboratory of Hygiene for more than 20 years. He is Professor of Pathology and Preventive Medicine and has served as director of the State Laboratory of Hygiene.

"Workshop on CME Leadership" offered nationally

The Illinois Council on Continuing Medical Education can now offer its unique "Workshop on CME Leadership" anywhere in the nation. This short (3-hour) workshop was designed especially for hospital medical staff leadership. It provides (a) an overview of CME planning and (b) opportunity for the seminar group to identify its institution's CME problems and begin to seek solutions. It is offered in the hospital or any nearby site chosen by the institution, on a contract basis for up to 12 participants. Participants earn 3 hours of Category I CME credit. For details, ask for the brochure, "Workshop on CME Leadership" from: Illinois Council on Continuing Medical Education, 55 East Monroe St, Suite 3510, Chicago, Ill 60603.

News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Milwaukee Psychiatric Hospital has announced its 1980-81 Medical Conference series on "Medical and Social Aspects of Mental Illness." Sessions began September 10 and continue through May 20, 1981. Each session will be held from 10:15 am until 12:15 pm in the gym on the Hospital grounds. There will be two sessions each month except in December and April, when only one is planned, according to Philip E Veenhuis, MD, director of medical education for the Hospital.

The series is presented by the Hospital's Outpatient and Community Services Center and cosponsored by the Medical College of Wisconsin, Department of Psychiatry and Mental Health Services. The program includes a three-part mini course on sociopathy that will be offered on February 25, March 11 and 25.

Doctor Veenhuis said the Medical College of Wisconsin certifies that this continuing medical education activity meets the criteria for two credit hours in Category I of the Physician's Recognition Award of the AMA for each session attended. Those in other disciplines who attend may earn 0.2 continuing education unit credits.

Persons who wish further information may phone 258-2600, extension 302.

The remaining schedule of medical conferences follows:

November 5: Frederick T Hallanger, BA, M DIV, Pastor, Calvary Lutheran Church, Brookfield; Director, Community Counselor and Consultation Services, Brookfield. "Clergy Counselors: Their Competence—Compared to Other Therapists—Use of Religious Insights in Treatments—Source of Referrals."

November 19: Earl Suttle, Executive Director; Wellington Warren, Associate Director, Urban Institute. "Black Issues in Therapy."

December 10: Richard Kirsch, MD, Program Director, Dewey Center, Milwaukee Psychiatric Hospital. "Fetal Alcohol Syndrome."

January 7: Morton Josephson, MD,* Clinical Director, Milwaukee Psychiatric Hospital. "Hypnosis in Medical Practice."

January 21: Eugene Dagon, MD,* Assistant Professor, Department of Psychiatry and Mental Health Sciences, Medical College of Wisconsin, Director of Geropsychiatry. "Reconceptualizing the Care of the Elderly at Home and in Institutions."

February 11: Thomas Erck, PhD, Staff Psychologist, Curative Rehabilitation Center. "Psychological Aspects of Cardiac Rehabilitation."

The mini course, titled "The Superego and the Failure of Moral Development," is a three-part series dealing with the problems of conscience, behavior, and the rules of society.

February 25 (first in a three-part series): Ikar Kalogjera, MD, Assistant Professor, Department of Psychiatry and Mental Health Sciences, Division of Child and Adolescent Psychiatry, Medical College of Wisconsin. "The Role of Cultural Myths on the Development of Socially Acceptable and Unacceptable Behavior." (The issues of freedom, responsibility, individualism, and social controls.)

March 11 (second in a three-part series): Arthur G Norris, MD,* Attending Staff, Milwaukee Psychiatric Hospital. "The Development of Sociopathy." (Biological, psychological, and social issues.)

March 25 (third in a three-part series): Clifford J Simske, MD,* Attending Staff, Milwaukee Psychiatric Hospital. "The Treatment of Superego Pathology." (Cognitive therapy and rationale-motive therapy—Is this all we have to offer?)

April 8: Bela Selan, MS, Coordinator, Mental Retardation Program, Psychiatry Clinic, Mount Sinai Hospital, Milwaukee. "Psychotherapy with the Developmentally Disabled and Elderly."

May 6: James Halikas, MD, Associate Professor, Department of Psychiatry and Mental Health Sciences, Medical College of Wisconsin; Director of Southeastern Wisconsin Institute on Alcoholism. "Adolescents Who Get High: Criteria for the Diagnosis of Alcohol Abuse and Drug Abuse in Adolescents."

May 20: Edward S Friedrichs, MD,* Assistant Clinical Professor, Department of Psychiatry and Mental Health Sciences, Medical College of Wisconsin. Internist in Private Practice. "Sleep: A Psychosomatic Link."

St Luke's Hospital and St Luke's Hospital Foundation, Inc, Milwaukee, will sponsor a national symposium on the etiology, diagnosis, and medical-surgical management of coronary heart disease in Milwaukee, April 9-11, 1981, at the Hyatt Regency Hotel. A faculty of 32 heart specialists will present the symposium titled "Coronary Heart Disease—1981" which is designed for cardiologists, cardiovascular and thoracic surgeons, internists, and family practitioners. Data collected from heart centers in Milwaukee, Cleveland, Texas, and Montreal, Canada on coronary bypass surgery will be compared in a special session. These comparative surgical results over five and ten year periods are being made available for the first time—a special feature at this symposium, according to the sponsors. These results also will be compared to those treated medically and surgically in randomized and matched

New patient recordkeeping guide available

A new "how-to" guide offering internists the nuts-and-bolts information needed to design an effective recordkeeping system has been developed by the American Society of Internal Medicine (ASIM). "Patient Records: A Guide for Your Practice," helps internists to assess their own information needs, and then to design and implement a recordkeeping system best suited to their practices. Helpful tips on office work flow, filing systems, and computer use are included. While specifically addressing the needs of broad-based internists, the guide is also helpful to the subspecialty practices of internal medicine. Internists new to practice and setting up recordkeeping systems for the first time, may find it especially useful. ASIM is a federation of 51 component societies representing more than 17,000 internists nationwide. The guide is available at $7.50 a copy; bulk rate (50 or more copies) is $7.20 a copy. Send check or money order to ASIM, 2550 M St, NW, Suite 620, Washington, DC 20037.

International Physicians group to expand membership development

Fellows of the American College of International Physicians, Inc have recommended to the College's Board of Trustees an expanded membership development program to recruit more interested physicians into the College.

The ACIP was organized in 1975 as a nonprofit participatory Fellowship for physicians educated in medical schools abroad and in the United States, who are licensed and practicing in the United States. The Fellowship is open to all physicians who wish to join their colleagues from many nations and around the world in a cooperative endeavor to shape policies for the future of medicine in the United States and around the world in the fields of medical education, research, ethics, and international health activities.

The College provides a forum for the discussion of issues of vital interest to international physicians and international medicine. It is actively working to help create a climate conducive to the development of the full potential of all international physicians now practicing in the American continent and is helping formulate the national interest in international health activities because of the unique internationality of its Fellowship and its expertise in the health needs of countries abroad.

Fellowship information and application forms can be obtained by writing the College's office at 3030 Lake Avenue, Fort Wayne, Indiana or by calling (219) 424-7414.

studies. Also included are discussions of the role of risk factors, cardiac rehabilitation after infarction and after coronary bypass surgery, newer echo and nuclear studies, complications of acute infarction, vasospastic angina, and coronary transluminal angioplasty among other topics during this three-day conference.

The symposium has been approved by and is presented in cooperation with the Wisconsin Academy of Family Physicians, American Heart Association/Wisconsin Affiliate, American Heart Association Council on Clinical Cardiology and the American Heart Association Council on Cardiovascular Surgery. Chairman is John C Manley, MD,* cardiologist at St Luke's Hospital and associate clinical professor of the Medical College of Wisconsin.

Advance registrations are now being accepted for the symposium which offers 16 credits in Category I of the Physician's Recognition Award of the American Medical Association and 16 credits from the American Academy of Family Physicians. The fee is $250 and includes all conference materials, three lunches, and a special evening of refreshments and entertainment.

More information and registration materials can be obtained by writing Ms Dorothy Black, Public Relations, St Luke's Hospital, 2900 West Oklahoma Ave, Milwaukee, Wis 53215; phone: 414/647-6388.

University of Wisconsin Medical School researchers have received a $300,000, three-year grant to study a new computerized x-ray technique. The grant was awarded by the National Heart, Lung, and Blood Institute of the National Institutes of Health. Charles Mistretta, professor of medical physics, and Dr Charles Strother, associate professor of radiology and neurology, are principal investigators for the project. The researchers will evaluate the effectiveness of computerized fluoroscopy, an x-ray procedure developed at the University of Wisconsin Hospital & Clinics and Medical School, in detecting disease in arteries to the brain. Results will be compared to those obtained using arteriography.

The Jackson Clinic's medical director, Blake E Waterhouse, MD,* Madison, announced the appointment of five new physicians to its medical staff. They are MDs Karen R Brungard, internist; Paul Hinderaker, cardiologist; Geoffrey R Priest, internist specializing in pulmonary medicine; Norbert F Toussiant Jr, an ophthalmologist; and Gary B Zoellner, an orthopedic surgeon. Doctor Hinderaker and Priest are Board certified in internal medicine and Doctors Brungard, Toussiant, and Zoellner are Board eligible. Doctors Toussiant and Brungard completed their residencies at the Mayo Clinic, Rochester; Doctor Hinderaker at Yale; Doctor Priest at Dartmouth Medical School, and Doctor Zoellner at the University of Wisconsin Medical School, Madison. ■

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ©IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

ESIC—Abbreviated Summary

CATIONS: Based on a review of this drug by the nal Academy of Sciences—National Research cil and/or other information, FDA has classified dications as follows

sibly* effective for the treatment of pain accom- d by tension and/or anxiety in patients with mus- keletal disease or tension headache

F classification of the less-than-effective indica- requires further investigation.

effectiveness of Equagesic in long-term use, i e than four months has not been assessed by matic clinical studies. The physician should pe- ally reassess usefulness of the drug for the indi- patient.

ON UNDICATIONS: Equagesic should not be given to s with a history of sensitivity or severe intolerance meprobamate, or ethoheptazine citrate

AR GS: Careful supervision of dose and amounts pre- or patients is advised, especially with those patients m propensity for taking excessive quantities of drugs and prolonged use in susceptible persons, e g , former addicts, and other severe psychoneurot- een reported to result in dependence on or habit- the drug Where excessive dosage has continued , or months, dosage should be reduced gradually n abruptly stopped, since withdrawal of a "crutch" pitate withdrawal reaction of greater proportions or which the drug was originally prescribed Abrupt ance of doses in excess of the recommended dose ed in some cases in the occurrence of epileptiform

re should be taken to warn patients taking mepro- at tolerance to alcohol may be lowered with re- wing of reaction time and impairment of judgement ination

ACN PREGNANCY AND LACTATION: An in- sk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepem) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e.g , caffeine Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disapoears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, Pa 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed

WHY NOT WYGESIC® CIV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had historios of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphorie, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can sorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic action and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (within hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine which may cause anorexia, nausea, vomiting, and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 20-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 7tfn/80

Internist wanted to practice in conjunction with a six-member Internal Medicine Department of a 20-physician multispecialty group, located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen L Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. Phone: 414/632-7521. 8tfn/80

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

General Internist: Join an 18-physician multispecialty clinic in Appleton, Wis. Have departments in pediatrics, surgery, family practice, internal medicine and OB/GYN. Need another internist. Excellent hospitals, guarantee and incentive compensation. Complete benefit package. Medium-size community with excellent educational, cultural, recreational, and shopping opportunities. Contact Art Schuetze, Medical Arts Clinic, SC, 401 North Oneida St, Appleton, Wis 54911. Phone: 414/739-0171. 9-11/80

Fifty-physician multispecialty clinic in West Central Wisconsin wants allergist, cardiologist (noninvasive), pediatrician, and family practitioner to do acute medicine. Also family practice openings in nearby satellite offices. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Admin, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5266. 9-12/80

Two-three Board eligible/certified family physician's needed in Northeastern rural Wisconsin. New clinic adjacent to fine 60-bed hospital. Financial assistance available and negotiable. Excellent location, community atmosphere and economy. Contact J Schumacher, Admin, Calumet Memorial Hospital, Chilton, Wis 53014. Phone: 414/849-2386. 10-12/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Southeastern Wisconsin. Expanding emergency service, St Mary's Medical Center, Racine, has openings for experienced emergency physicians. American graduates, HCLP, ACLS. Fee for service. Forty-hour week. Send curriculum vitae to Director, Emergency Services, St Mary's Medical Center, Racine, Wis 53405. Phone: 414-636-4011. 9-10/80

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

The Wisconsin Veterans Home has an immediate vacancy for a staff physician. Institutional geriatric practice at 700-bed state operated Veterans Home. Located in an excellent summer and winter recreational area, the Wisconsin Veterans Home offers a challenging medical opportunity with the additional benefits associated with small community living. We offer competitive salary starting to $63,000—increase to $70,000 on 7/1/81, liberal fringe benefits (40% fringe); regular hours, paid malpractice insurance, and other benefits. Contact: John Peters, Personnel Manager, Wisconsin Veterans Home, King, Wis 54946. An Equal Opportunity Employer. 10/80

General surgeon wanted to join young general surgeon in a 26-member multispecialty group in town of 35,000 with good drawing area. 350-bed hospital. Negotiable salary guarantee. Contact William Sybesma, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 12tfn/79

OBSTETRICIANS-GYNECOLOGISTS WANTED

Obstetricians-Gynecologists board certified or eligible wanted to join in practice with obstetrician-gynecologist in a city of 100,000 on Lake Michigan between Milwaukee and Chicago. Excellent schools, medical school affiliation, security of freedom of practice in independent small group. Contact: Elizabeth A Steffen, MD, 734 Lake Ave, Racine, Wis 53404. Phone: 414/637-8311. 6tfn/80

Physicians Exchange

continued

Multispecialty Group of 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Dermatologist

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. No personal investment. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 10/79

Internist—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

General surgeon wanted to join group of six family practice physicians in a rural community of northwestern Wisconsin. For additional information contact F H Goetsch, MD, Spooner, Wis 54801. Phone: 715/635-2151. 8-10/80

Rheumatologist wanted to join four orthopedic surgeons in a very desirable north central Wisconsin community with a drawing population of 70,000. Active practice assured, shared "on call" provided, research grants available. New Clinic facility located within new 35 million dollar hospital complex. Outstanding personal benefit programs, generous guaranteed income. For further information contact: Lloyd Engstrom at 715/842-3202, or write PO Box 1646, Wausau, Wis 54401. 8-12/80

Family Practitioner wanted: 13-man, mixed group practice seeking family practitioner to join its Family Practice Department of six family practitioners located 100 miles south of the Twin Cities in a community of 25,000. Ideal community with excellent schools and multiple recreational opportunities, new hospital. Liberal benefits and top salary offered. This is a choice practice opportunity in rural southern Minnesota. Please contact James Burns, MD, 210 N St Mary St, Albert Lea, Minn 56007. Phone: 507/373-1441. 10-12/80

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FHP

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HMO MEDICAL DIRECTOR

FHP, located in the southwestern section of the Milwaukee metropolitan area, is seeking a qualified Medical Director to direct the organization of the medical delivery system for a federally qualified, staff model HMO. FHP is a new, modern facility which began operations in February, 1979. Presently, eight staff physicians provide health care in this single health care center, along with ancillary services including x-ray, laboratory, pharmacy, optometry, and social services. FHP offers a top fringe benefit package; malpractice insurance paid; relocation fully paid.

SPECIAL REQUIREMENTS: Board certified or Board eligible.
SALARY: Open.
CONTACT: James Cleffey, Acting Executive Director.

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Family Practitioner, wealthy agricultural area 1 hr/Minneapolis, St Paul, near abundant lakes, forests; ideal working setup and future with excellent financial potential of easy $150,000. Contact Dept 483 in care of the Journal. 10/80

OB-GYN to do gynecology and high-risk OB to join 12 physician primary care practice in northwestern Wisconsin. New 75-bed hospital and new clinic, 100 miles from the Twin Cities. Lester A Thompson, MD, 1020 Lakeshore Dr, Rice Lake, Wis 54868. 10-12/80

Family Physician or Internist (3rd year resident okay) for Madison clinic to consult on integrative treatment regimen (part-time). Growth opportunity. Send CV and letter to Dept 482 in care of the Journal. 10/80

Family Practice. Wanted a family practitioner to locate in new clinic building in Poynette, Wis. Located 30 miles from Madison, Wis. Poynette is a village of approximately 1000 with a service area of 7000 persons. Salary guaranteed. Contact John Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 10tfn/80

Racine Medical Clinic, SC, multispecialty group of 20 physicians has a practice association for:

- Family/General Practitioner
- General Surgeon
- Pediatrician

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 9tfn/80

Wanted. Board Certified or Eligible OB/GYN; immediate opening with 8 physicians; multispecialty group of 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon. Clinic building is next to community hospital; expanding service area in western Milwaukee metro fringe location; first-year salary with optional second-year corporate stockholder; excellent fringe benefits including pension and profit-sharing plans. Contact J L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone 414/673-5745 collect. 5tfn/80

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Locum Tenens work wanted. Family and general practice, open availability. T C Kolff, MD, 801/566-1666. 9-11/80

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Licensed Employment Agency 9tfn/79

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Hematology/Oncology
- Otolaryngology

Beautiful new building adajacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Indiana—Fort Wayne: Emergency physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc, 4400 Broadway, Suite 306, Kansas City, Missouri 64111, 816/931-3040. 10-12/80

Board certified general surgeon desires to relocate in Wisconsin near large city. Wisconsin license. Willing to do some general practice. References upon request. Contact Dept 481 in care of the Journal. 7-11/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

The Department of Family Practice, The Medical College of Wisconsin is recruiting for an Assistant Director of a 12-resident Family Practice Program. Directorship open within 5 years. Practice experience and Board certification required. City of 50,000, Southeastern Wisconsin, excellent schools, 20 miles from Milwaukee, superior living. Contact: Director, Waukesha Family Practice Residency Training Program, 434 Madison St, Waukesha, Wis 53186. Phone: 414/544-5959, call collect. 10/80

Medical Facilities

Office space available in southeastern Wisconsin near 200-bed hospital. Fully equipped, suitable for a Family Practitioner. Metropolitan Milwaukee area. Contact Dept 484 in care of the Journal, or phone 414/965-2200. 10tfn/80

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095
8-12/80,1-7/81

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For lease: Approximately 1500 sq ft, furnished or unfurnished, in West Milwaukee, edge of Wauwatosa. 9300 West Capitol Dr, Milwaukee. Perfect for Internist or Family Practitioner. Four exam rooms; consultation, lab, insurance, and waiting rooms. Favorable terms. For further information contact: Phone 414/463-6650. 9tfn/80

For Sale: Zeiss Photomicroscope with circular rotating and centering mechanical stage, automatic exposure device and full power pack. Several objective and ocular lenses. Excellent condition. Regularly maintained by manufacturer's representative. Contact Mr. Bernard Goldstein, 606 West Wisconsin Ave, Milwaukee, Wis 53203. Phone: 414/271-1400. g10tfn/80

For Sale: Professional office building in Milwaukee. Approximately 2700 sq ft presently houses three dentists and hearing aid office. Central air, new roof, private parking area. Excellent tax write off. Very reasonable. Call after 7 pm 414/258-8555. p10/80

Real Estate

For Sale: John Hancock condo on Magnificent Mile. Walking distance Northwestern Hospital and University. Also easy access other universities and hospitals. Many high caliber professional and corporate executive unit owners. Amenities included in assessment: large all-year indoor pool, saunas, exercise rooms, eliminates outside health club membership, laundry rooms throughout, bicycle rooms, your own private storage locker on floor. Inside building; access to garage, office building, shops, and bank. 44th floor private lobby has commissary, restaurant for unit owners and guests, receiving room, valet shop, party room. Large one bedroom 76th fl apartment, unobstructed view Lake Michigan; eat in kitchen, 2 huge walkin closets, linen closet, levelor blinds, white sheer draw curtains, unusual parquet floors. Many other features for those who demand the best in living. Low monthly assessment and taxes. Price $165,000 negotiable. Private owner relocating. Call collect 312/664-4665 after 5 PM excluding 11/22 through 11/30. Principals only. p10/80

Announcements

National Rural Primary Care Association is sponsoring a Call for Papers for the Fourth National Conference on Rural Primary Care to be held March 7-12, 1981 in Denver, Colorado. Anyone wishing to receive further topic information and the criteria which will be used in the selection process should send name, address, and phone number to: Vicki Coates, Search Committee, NRPCA, Box 1211, Waterville, Maine 04901.

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Total distribution	5639	5647
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TOTAL	5723	5750

I certify that the statements made by me are correct and complete.
/s/ MARY ANGELL
Managing Editor

Date of filing Sept. 17, 1980
PS Form 3526, modified above for purposes of printing.

Bookshelf

New books received *are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.*

Law for the Medical Practitioner. By Charles W Quimby, Jr, MD, LLB. Health Administration Press, Dept LMP, M2240 School of Public Health, The University of Michigan, Ann Arbor, Mich 48109. 1980. Pp 187. Price: $15.00.

Molecular Interactions and Activity in Proteins. Ciba Foundation Symposium 60. CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, NJ 97901. 1979. Pp 279.

Food Power. By George Schwartz, MD. McGraw-Hill Book Co, 1221 Avenue of the Americas, New York, NY 10020. 1979. Pp 189. Price: $10.95.

Sex, Hormones and Behaviour. Ciba Foundation Symposium 62, CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, NJ 97901. 1979. Pp 382.

Footnotes. By Michelle Arnot. Doubleday & Company, Inc, 245 Park Ave, New York, NY 10017. 1980. Pp 164. Price: $5.95.

Microbial Diseases. Editor, Carl W. May. William Kaufmann, Inc, 1 First St, Los Altos, CA 94022. 1980. Pp 322. Price: $7.95.

Basic & Clinical Immunology. Edited by H Hugh Fudenberg, MD; Daniel P Stites, MD; Joseph L Caldwell, MD and J Vivian Wells, MD. Lange Medical Publications, Drawer L, Los Altos, CA 94022. 1980. Pp 782. Price: $17.50.

Toward Fitness. By Robert C Cantu, MD,FACS. Human Sciences Press, 72 Fifth Ave, New York, NY 10011. 1980. Pp 258. Price: $11.95.

Public Relations in the Emergency Department. By Cyril T M Cameron, MD. Robert J Brady Co, Bowie, Md 20715. 1980. Pp 126. $14.95. ■

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of poblication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

NOVEMBER 5-7: *Aging and Illness in Primary Care—Basic and Clinical Science Foundations.* Wisconsin Center, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and University of Wisconsin-Madison, School of Medicine, Departments of Medicine and Family Medicine and Practice. Fee: $215. 21 credit hours Category 1 of AMA; AAFP credit. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

NOVEMBER 7: Wisconsin Orthopedic Society meeting, starting at 9:00 am, Olympia Princess, Scottsdale Resort, Oconomowoc.

NOVEMBER 6-8: *2nd Annual Respiratory Critical Care Symposium: Acute Respiratory Failure—Admissions to Discharge.* The Inn on the Park, Madison. Sponsored by the University of Wisconsin-Extension, Continuing Medical Education Program Unit and the University of Wisconsin Center for Health Sciences. Fee: $150/physician; $100/nurse, resident, allied health professional. 15 credit hours of Category 1 of AMA and Family Physician credit applied for. 1.5 CEU units. Info: Sarah Z Aslakson, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Toll free number 1-800/362-9080.

NOVEMBER 8, 1980: *Fall Ultrasound Conference:* Abdominal Ultrasonography Update on Selected Topics. Fee: $35. Contact: Thomas L Lawson, MD, Dept of Radiology, Milwaukee County Medical Complex, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226; phone: 414/257-6024. Category 1—4 hours.

NOVEMBER 12, 1980: *One-Day Seminar for Family Physicians,* Bellin Memorial Hospital, Green Bay. Approved for 4 hours of credit (per meeting) in Category 1 of the PRA-AMA. Further information, contact Arlene K Meyer, 1-800/362-9080.

NOVEMBER 15-16, 1980: *Therapeutics II—1980.* UW Clinical Science Center, Madison. Fee: $115. Credit: Nine hours Category I AMA applied for; AAFP credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone 608/263-2856.

JANUARY 15-21, 1981: Fourteenth Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics and Endocrinology,* sponsored by the Medical College of Wisconsin, Milwaukee, at the Pfister Hotel and Tower, Milwaukee. Among guest faculty will be: H W Jones Jr, MD; Georgeanna S Jones, MD; J D Woodruff, MD; and Robert Young, MD (NCI). Approved for 42 cognate hours, Formal Learning, by American College of Gynecologists and meets criteria for 42 hours of credit in Category I for the PRA-AMA. Also approved for 42 elective hours of credit by the American Academy of Family Physicians. A $475 enrollment fee will include 68 selected 35mm slides. Registration fee is nonrefundable. Further details and registration, write to: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis. 53226.

JANUARY 23-24, 1981: *First Annual Seminar on Clinical Genetics,* The Wisconsin Center, Madison. Approved 16 credit hours Category I of AMA and AAFP. Fee: $190. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone: 608/263-2856.

WISCONSIN continued

MAY 4-6, 1981: *Intravenous-Arteriography.* University of Wisconsin-Madison, Memorial Union, Madison. Approved 16 credit hours Category 1 and 16 hours American College of Radiology. Fee: $395. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone: 608/263-2856.

UPPER MIDWEST

NOVEMBER 2-7: Annual Meeting, American Academy of Ophthalmology, McCormick Place, Chicago, Illinois. (Relocated from New Orleans to accommodate increasing attendance.) Info: AAO, 1833 Fillmore St, PO Box 7424, San Francisco, CA 94120, or call 415/921-4700.

DECEMBER 10-12, 1980: *Neurology for the Non-Neurologist,* Sheraton Plaza Hotel, Chicago, Ill. Sponsored by Rush-Presbyterian-St Luke's Medical Center. Approved 20 credit hours of Category I of PRA-AMA. Info: Leslie Bryan, CME, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina St, Chicago, Ill 60612. 312/942-7095. 8,10,11/80

FEBRUARY 20-21, 1981 (KANSAS): American College of Physicians Meeting, Downtown Ramada Inn, Topeka. Info: Max S Allen, MD, University of Kansas Medical Center, 39th Street & Rainbow Blvd, Kansas City, KS 66112.

MARCH 2-6, 1981: Seventieth Annual Meeting of the United States-Canadian Division of the International Academy of Pathology, at the Palmer House, Chicago, Illinois. The Maude Abbott Lecture entitled "The Impact on Time on the Diagnosis and Treatment of Cancer: 1936-1981," will be delivered by Dr Lauren V Ackerman on March 3. Scientific papers, poster sessions, twelve specialty conferences, and 50 short courses are scheduled. A special course will be offered on "Immunopathologic Techniques in Diagnostic Pathology," with Dr Robert T McCluskey as course director. The long course will be on "The Inflammatory Process and Infectious Disease," with Doctors Guido Majno and Ramzi Cotran, course directors. Further info: Dr Nathan Kaufman, Secretary-Treasurer, United States-Canadian Division of the IAP, 1003 Chafee Avenue, Augusta, Ga 30904; telephone: 404/724-2973. g7-12/80

MARCH 20-21, 1981 (NEBRASKA): American College of Physicians Meeting, Omaha. Info: Bowen E Taylor, MD, Box 81009, Lincoln, NE 68501.

APRIL 5-9, 1981 (ILLINOIS): American Society of Neuroradiology, Chicago, Ill.

APRIL 6-9, 1981 (MISSOURI): 62nd American College of Physicians Annual Session, Kansas City. Info: Robert H Moser, MD, FACP, Executive Vice President, 4200 Pine St, Philadelphia PA 19104.

APRIL 30-31, 1981 (NORTH DAKOTA): American College of Physicians Meeting, Jamestown. Info: Harold W Evans, MD, 2624 Olson Drive, Grand Forks, ND 58201.

MAY 1-2, 1981 (IOWA): American College of Physicians Meeting, University of Iowa, Iowa City. Info: William B Galbraith, MD, 115 Eighth St NE, Cedar Rapids, IA 52401.

OTHERS

DECEMBER 6-11: American Academy of Dermatology, New York, NY. Info: AAD, Inc, 820 Davis St, Evanston, Ill 60201 (Phone 312/869-3954).

JANUARY 15-17, 1981 (COLORADO): American College of Physicians Meeting, Broadmoor Colorado Springs, Colo. Info: Edward S Miller, MD, 4567 East Ninth Ave, Denver, Colo 80220.

JANUARY 28, 1981 (HAWAII): American College of Physicians Meeting, Hilton Hawaiian Village, Honolulu, Hawaii. Info: James J Ball, MD, 1319 Punahou St, #1190, Honolulu, Hawaii 96826.

FEBRUARY 13-22, 1981 (CRUISE SHIP): *Symposium on Current Concepts in Diabetes and Radiology.* Cruise Ship S S Volendam. Ports of Call—Antigua, St Maarten, St Thomas, Santo Domingo. 48 credit hours Category 1 of AMA, LCCME Category 1. Educational program fee: $400. Info: Ann Bailey, CME, 610 Walnut St, Room 454, Madison, Wis 53706. Phone: 608/263-2854.

MARCH 7-12, 1981 (COLORADO): *National Rural Primary Care Association,* fourth national conference in Denver, Colo. Info: Search Committee, NRPCA, Box 1211, Waterville, Maine 04901; Attn: Vicki Coates.

MARCH 8-15, 1981 (HAWAII): Postgraduate Course in Sports Medicine, Sheraton Hotel, Maui, Hawaii. 25 hours of Category 1 of AMA-PRA. Course is scheduled to coincide with the Maui Marathon to accommodate those registrants who wish to participate in the race. Info: Marianne Porter, Center for Sports Medicine, 2-063, 303 E Chicago Ave, Chicago, Ill 60611. 10-12/80

APRIL 23-25, 1981: *American Cancer Society National Conference on Human Values and Cancer: Psychological, Social and Ethical Issues.* Washington Hilton Hotel, Washington, DC. 15½ credit hours of Category I of AMA/PRA. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference on Human Values and Cancer, 777 Third Ave, New York, NY 10017. g9tfn/80

MAY 2-22, 1981: *Program in Health Policy, Planning and Regulation,* conducted at the Harvard School of Public Health by an interdisciplinary faculty drawn from the Harvard Graduate Schools of Public Health, Business, Law, Medicine, Government, and Arts & Sciences. Intensive training in management and analytic skills for senior leaders in health delivery and health-related organizations. Info: Assistant Director for Administration, Executive Programs in Health Policy and Management—Dept NR, 677 Huntington Ave, Boston, MA, 02115.

JUNE 21-JULY 31, 1981: *Program for Health Systems Management,* conducted at the Harvard School of Public Health by an interdisciplinary faculty drawn from the Harvard Graduate Schools of Public Health, Business, Law, Medicine, Government, and Arts & Sciences. Focuses on the managerial skills of leadership, resource allocation and institutional policy and strategy required by senior executives in health industry organizations. Info: Assistant Director for Administration, Executive Programs in Health Policy and Management—Dept NR, 677 Huntington Ave, Boston, MA 02115.

AMA—1980

DECEMBER 7-10: Interim AMA House of Delegates, San Francisco Hilton, San Francisco, Calif. ■

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JCAH BOARD SETS GUIDELINES FOR QUALITY ASSURANCE. At its meeting in August the Board of Commissioners (BOC) for the Joint Commission on Accreditation of Hospitals reaffirmed January 1, 1981 as the implementation date for the new quality assurance standards for the hospital and psychiatric accreditation programs. These standards call for development of a facility-wide program that integrates and coordinates all quality assurance activities. The purpose of the quality assurance program is to identify and resolve important problems in patient care. The BOC recognized that, given the complexity of implementing a comprehensive quality assurance program, it will probably take some time for complete development in all hospitals and facilities. Consequently, the BOC made two important decisions concerning the approach that the JCAH will take to quality assurance in 1981.

First, the survey process will cover all aspects of the quality assurance standards. Surveyors will comment on the quality assurance program at the summation conference, and when indicated, recommendations for improvement in any aspect of the program will be returned to the facility as a part of the survey report. Secondly, the Accreditation Committee of the Board of Commissioners, in making final decisions for facilities surveyed for compliance with standards contained in the *Accreditation Manual for Hospitals* and the *Consolidated Standards for Child Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs,* will focus its attention upon whether a facility has designated the authority and responsibility for quality assurance, whether it has progressed toward coordination and integration of existing quality assurance mechanisms, and whether it has a written plan that reflects the assignment of authority and responsibility and specifies mechanisms or projected mechanisms for integration and coordination.

WHAT ABOUT THE LAWYER GLUT? While the federal government is predicting a physician glut by 1990, no one seems interested in or worried about the current population explosion of licensed lawyers in the nation. According to Associate US Attorney General John Shenefield, there are more than 500,000 practicing attorneys in this country, translating to one for every 450 Americans, who are responsible for an estimated 1.25 percent of the country's GNP—more than electric power or steel. By comparison, the People's Republic of China has almost no lawyers; Japan has about 10,000, or one per 10,000 Japanese; and Europe has approximately 35,000 or one for every 1,500 people. In Washington, he says, there is one lawyer for every 80 residents.

PHYSICIANS NOTE: PRESCRIPTION DIVERSION CONTROL PROGRAM INITIATED. Wisconsin Controlled Substances Board (Darold A Treffert, MD, chairperson) recently entered into written agreements with the Drug Enforcement Administration and the licensing boards in medicine, pharmacy, dentistry, and veterinary medicine, to curb the diversion of prescription drugs which are involved in more than half of the cases of drug abuse and drug-related death. This will involve close collaboration in the monitoring of legally dispensed controlled substances.

MEDICAL EXAMINING BOARD MEMBERS NAMED. Walter L Washburn, MD of Madison was chosen secretary of the State Medical Examining Board at its August 28 meeting in Madison. New members of the Board, pending Senate approval, are Adolph L Gundersen, MD, LaCrosse; and Ms Gwen T Jackson, Milwaukee, the citizen member to succeed Attorney Mary Reddin, Wauwatosa, whose term expired May 1. Other members of the MEB are: MDs Nelson A Moffat, Marshfield (chairman); Rudolph W Link, Madison (vice-chairman); George M Daley, Milwaukee; Richard A Eckberg, Stevens Point; W Dudley Johnson, Milwaukee; and DO Thomas Roskos, Hartland. Doctors Washburn and Link and consumer representative Jackson also represent the Board on the Joint Impaired Physician Committee.

STUDY OF NURSING HOME SURVEY METHODS UNDERWAY. Wisconsin Health Care Review Incorporated (WHCRI), has received a Federal grant to study alternative methods of conducting the state survey of nursing homes in Wisconsin. The findings of the study will be used by State and Federal officials in their revision and implementation of nursing home survey methods including application to PSRO mandates. WHCRI is seeking the cooperation of the major health associations by creating a special Health Professions Coordination Panel to assure coordination of the study and to communicate project goals and conclusions to the professional community. WHCRI welcomes questions and inquiries. Contact Cameron G Brown, Executive Director, WHCRI, at 608/273-1145. ■

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

NEW LAW ALLOWS FOR PAYMENT OF TITLE II SS DISABILITY MEDICAL CLAIMS. The Bureau of Social Security Disability Insurance has announced that after December 1, 1980, through an act of Congress, it will be able to pay for medical evidence of record for Title II Social Security Disability applicants. Since 1974 the Bureau has been making determinations of disability for the Title XVI Supplemental Security Income (SSI) program. The Bureau, however, has been unable to pay for the medical evidence of record of applicants for Title II because of the law indicating that applicants were responsible for supplying any evidence in support of their claims. As of December 1 this will change and the Bureau can pay for medical evidence of record for both programs. "Because of comparatively recent changes in the law it has become more and more important for the Bureau of Social Security Disability Insurance to have a very tight timeframe in which to get out the Bureau's decisions," said Dr Henry A Anderson, the Bureau's chief medical consultant. "The speed with which we can make our decisions depends a great deal on the time it takes to get the medical evidence of record from the treating physicians. Eighty percent of our decisions are made on the information supplied by the treating physician. Twenty percent require additional examinations to establish whether or not the applicant qualifies under Social Security Administration rules and regulations. Anything the physician can do to speed up the return of the information which is requested by the Bureau would surely be appreciated by the patient/applicant as well as the personnel in the Bureau office," Doctor Anderson noted.

PHYSICIANS ASKED TO HELP PREVENT MEASLES OUTBREAK. Wisconsin physicians recently were mailed an "open letter" from SMS President Russell Lewis, MD, and Division of Health Acting Administrator Terry Willkom asking them to prevent a new epidemic of measles by promptly reporting all suspected and known measles cases to their local public health agency. The letter also gave physicians information on the status of childhood immunization in cities and counties in Wisconsin. Doctor Lewis urges all physicians to first study the immunization statistics contained in the letter and then set out to work on improving immunization levels in their communities.

PPIs TO BE INCLUDED IN TEN PRESCRIPTION DRUGS. The Federal Food and Drug Administration will require patient package inserts (PPIs) in ten widely prescribed drugs beginning in mid-1981. ***Drugs included under the new three-year trial program are: ampicillins, benzodiazepines, cimetidine, clofibrate, digoxin, methoxsalen, thiazides, phenytoin, propoxyphene, and warfarin.*** The ruling is a scaled-down version of an earlier proposal by the FDA to include PPIs in 100 drugs—a program which the drug industry said would cost as much as $720 million a year. The leaflets, which are expected to cost about 18 cents each, will be produced by drug manufacturers and distributed by physicians and pharmacists. The government will reimburse drug companies for those leaflets included in Medicare and Medicaid prescriptions (about 10% of the total prescriptions filled annually), and the drug companies will bear the cost for the remaining 90%.

THREE-LEVEL MEMBERSHIP STRUCTURE DOES NOT VIOLATE ANTITRUST ACT, COURT RULES. Organized dentistry's three-tiered membership structure does not suppress competition, a Federal District Court in Phoenix, Arizona has ruled. The lawsuit began in 1972 when four dentists charged that an agreement between the American Dental Assn, the Arizona State Dental Assn, and the Central Arizona Dental Society violated the Sherman Antitrust Act by requiring a dentist to pay dues to all three as a condition of membership in any one of the three. The court ruled that the associations' membership rule "does not suppress competition between dentists within the state of Arizona or between dentists in Arizona and dentists in other states," and that neither the defendant associations nor their members have monopolized the practice of dentistry in Arizona. The case was being monitored by several other national associations, including organized medicine, that have state and local affiliate groups. *continued on page 63*

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WISCONSIN MEDICAL JOURNAL

NOVEMBER 1980

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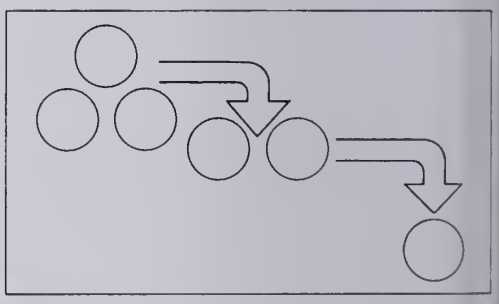
*Sellers EM: *Drug Metab Rev 8*(1):5-11, 1978



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Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy

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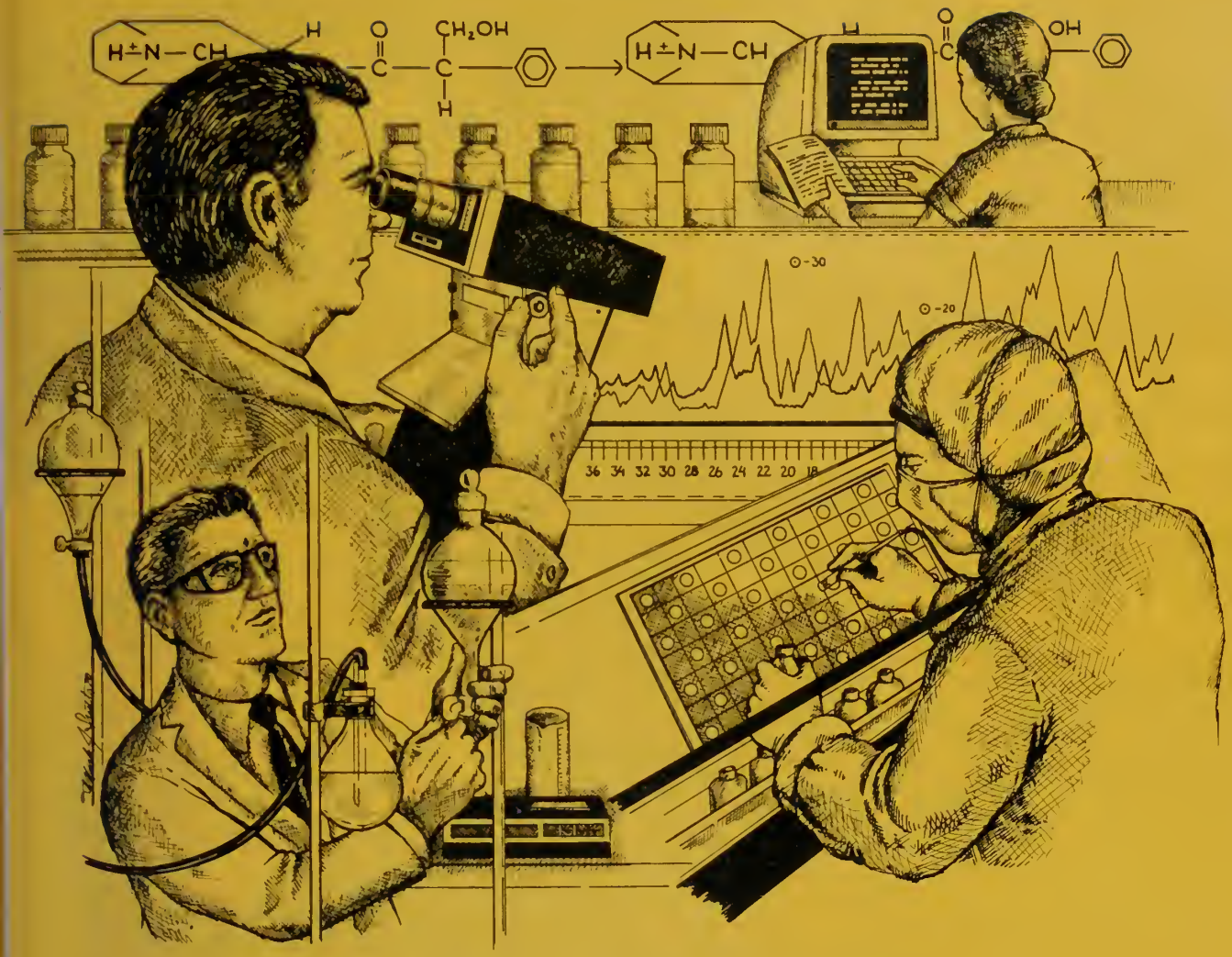

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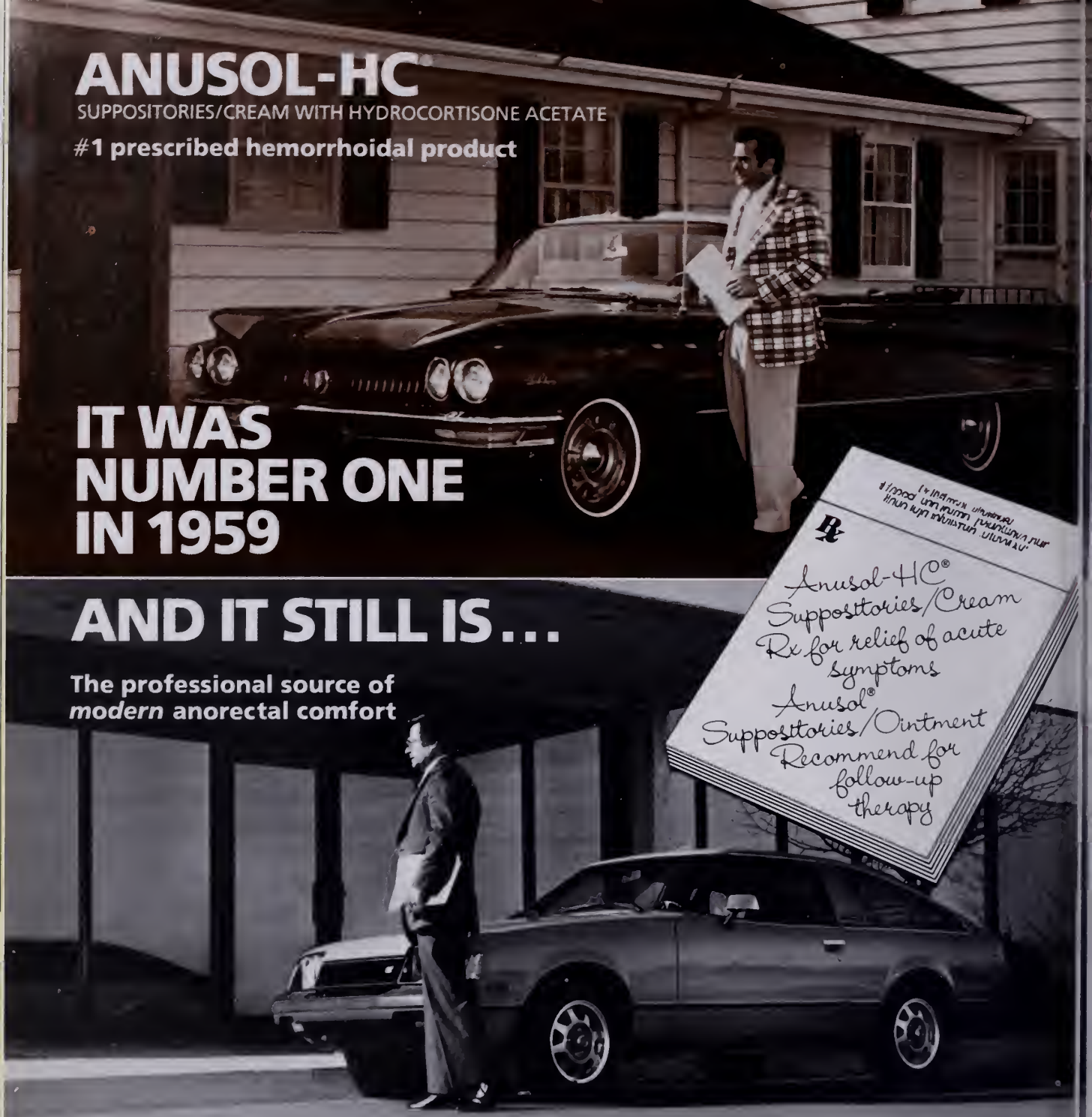

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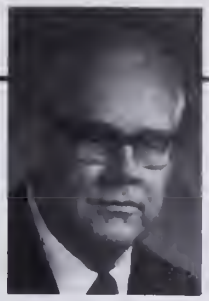
President's Page



Russell F Lewis, MD

Membership

TODAY WE HEAR and read regularly that the usual-customary-reasonable fee as we have known it is an idea whose time has passed. Increasingly government and insurance companies are promoting that concept and trying to replace it with some form of a uniform fee schedule. Certainly the Department of Health and Social Services in Wisconsin is looking at that seriously as a means of controlling costs in the State's ever-increasing struggle to do so with the Medicaid program. For an increasing number of physicians in particularly underserved, low-income regions, this concept is gaining more approval. If and when this approach to reimbursement becomes reality, medicine will need a very strong negotiating body. We should be gearing up for that eventuality now.

We should have learned a lesson from countries such as England where they split physicians into specialties and played the family practitioners against the surgeons, the surgeons against the internists, and so on. To me, this means that specialty societies should not be the primary organizations that enter into negotiations with insurance companies or the government.

This then brings us to membership in the State Medical Society. The American Medical Association now speaks for less than fifty percent of practicing physicians in the United States, a fact that is well known in Washington. Fortunately Wisconsin has had a much better record than that. Here the majority of practicing physicians (80%) do belong to their county societies, the State Medical Society, and the AMA.

Dr Darold Treffert, chairman of the State Medical Society Council, has recently appointed a new membership ad hoc committee because the Council feels more responsibility to get involved in this matter. Because the Milwaukee and Madison communities have a high percentage of the nonmembers, probably residents and faculty associated with the medical schools, these areas will be looked at with special care. Medical faculties in many respects feel that organized medicine does not and should not speak for them since they see themselves as having different goals and objectives. It is my belief that as the reimbursement mechanism changes, and it is changing, they will find it more important to participate with medical societies. Resident and student groups, female physicians, and foreign medical graduates have all been targeted for special attention by the ad hoc committee.

One of my responsibilities on becoming president of this Society is to sign many letters going to newly licensed physicians in Wisconsin, to new members of the State Medical Society, and to physicians who chose to leave the Society. Many of these doctors have taken the time and trouble to write me to explain their decision. Most of them state that their reason is they do not care to belong to the AMA. Most often this is for philosophic reasons, occasionally for expense.

At the Annual Meeting of our House of Delegates in March of this year, for the third year in a row unified membership was an important topic. To make a change in this status, our Society requires a constitutional amendment needing a two-thirds vote. The actual vote showed the majority of delegates thought unified membership was not desirable. However, the two-thirds majority was not obtained. The issue will be voted on again at the Annual Meeting in Milwaukee in March 1981.

I would personally like to take a stand against unified membership and urge that the delegates listen to the county societies from whence they come and give serious consideration to rejecting the present policy.

I am fully cognizant of the value of all physicians belonging to the AMA. Indeed, this editorial is a plea for participation in membership in that organization. If the national organization does not have a majority of physicians, its voice is not as strong as it would be otherwise. Wisconsin has five delegates and five alternate delegates serving in the AMA House of Delegates. If our AMA membership drops substantially, we might lose a delegate and an alternate. There are other good reasons for belonging, but in my opinion the time has come to say that Wisconsin wishes to be counted with the

other 45 states that do not require joint membership.

It is my hope that if unified membership no longer exists, membership in the State Society would increase. At the same time it is my hope that AMA membership would likewise increase. Wisconsin physicians traditionally have been socially responsible. The Membership Committee will not be addressing this issue, but between its activities and hopefully favorable action against unified membership at the meeting in March by the House of Delegates, increased strength in the State Medical Society will result.

This brings me back to the original thought: in order for physicians to cope with the increasing pressure and demands of socio-economic conditions from government to business and labor, physicians must stand together. The larger the majority of physicians involved, the greater will be their voice; and as you all realize, the greater will be their financial ability to respond to those increasing outside pressures.

We know the AMA is actively embarking on a substantial program of membership development. I would hope that Wisconsin rejection of unified membership will not detract from AMA membership, but that through increased recruitment and retention activity the State Medical Society as well as the AMA would be better able to speak as the voice of medicine.

We should also like to believe that as specialty societies start looking at the issue, they would find that in the long run their groups would be better served by increased participation in organized medicine for these activities. Specialty societies may remain the backbone of scientific and educational programs, but in socio-economic issues physicians of all backgrounds in training must work together to promote the best possible healthcare for the people of this country. This can best be done by having a group of happy, free, independent physicians. ■

"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

GMENAC report

THE GRADUATE Medical Education National Advisory Committee (GMENAC) spent four years and $4 million dollars to prepare a report for the HSS Department. The committee had 21 members, 13 of whom were physicians, and was constituted to advise the department on trends in health profession requirements.

The conclusions of the committee have been widely publicized—that there will be 60,000 excess physicians in 1990, 130,000 excess physicians in the year 2000, and that there will be surpluses of physicians in 19 medical specialties.

The committee made more than 100 recommendations. Among the more important were: a reduction of 17% from 1978 levels of first-year students in medical schools; a moratorium on new medical schools, now 126; a severe restriction on the entry into practice of physicians trained in non-US medical schools; incentives to encourage residents to enter into specialties with a shortage; reductions in residency positions in over-supplied specialties; holding the number of physician assistants and nurse-midwives in training to current levels; discontinuance of the Fifth Pathway program; cut off federal education assistance to students attending foreign medical schools; and since GMENAC's charter has now expired, establishing the committee as a statutorily created body.

The report raises a number of questions of concern to physicians. How will limiting the number of physicians solve the problem of shortages in rural or poorer urban areas? Will the recommended changes stimulate increased interest in the training programs where there are anticipated shortages such as psychiatry, emergency medicine, nuclear medicine, and hematology-oncology? Will shortages result in some of the other specialties if the residency training programs are sharply curtailed as recommended? If there are fewer obstetricians, will family practitioners attend more deliveries? If the recommendations were not followed, would the natural course of events in supply and demand achieve much the same thing in the next two decades?

The number of students applying for medical schools all over the United States has been dropping off sharply in recent years. At a state institution such as the University of Wisconsin Medical School it has been computed that the average graduate will be $40,000 in debt. This is certainly a deterrent to prospective medical students. In addition, they are becoming increasingly aware of government involvement in regulating the practice of medicine.

As AMA executive vice-president James H Sammons wrote after reviewing the report: "History has shown that long-term medical manpower projections are extremely difficult to make, given changing economic trends, technological innovations, a mobile population, and a rise in demand for services."—VSF

Sports medicine—the newer anatomy

THE CHIROPRACTIC columnist continues to contribute his weekly advice. A recent one was devoted to football injuries.

This week's gem reports that "not so easily detected and far more threatening is a misplaced or damaged vertebra in the spinal column. If one or more of these bones is even slightly out of line, it can mean pressure on the nerves inside the spine and actual partial or complete paralysis of a vital organ such as the heart or the ears."

And when did the eighth, tenth and eleventh cranial nerves get inside the spine?—VSF

Cesarean deliveries

RECENTLY THERE were two articles on cesarean deliveries in the *Wisconsin Medical Journal.* One of these pointed out an increase in this type of delivery in Wisconsin and the other discussed the factors affecting cesarean birth rates and the undesirable sequelae to cesarean births.

Although the percentage increase in Wisconsin is great, the cesarean section rate is only slightly over 10 percent.

At a recent meeting a fellow editor of a medical journal from a neighboring state told of a great change in one aspect of his pediatric practice. In his area it has become the practice to have a pediatrician in attendance when a cesarean section is to be

performed. Since 25 to 30 percent of the deliveries at his hospital are by cesarean section, he frequently is at the hospital for one or more of these sessions on many nights. He said that in addition to the automatic scheduling of cesareans for breech presentations, they also were used in lieu of forceps delivery and for any slight deviation in the fetal monitor.

With that unusually high cesarean section rate, one also wonders what percentage of them might be done purely for the convenience of the obstetrician.—VSF

Ampicillin-resistant *H. flu*

HEMOPHILUS INFLUENZAE is a bacterium that was first isolated in 1892 and mistakenly labelled *influenzae* in 1920. It is a cause of pneumonia and meningitis and is also the second most frequent cause of bacterial bronchitis and of otitis media, which affects 95 percent of all children at least once by age five.

Since 1975 there has been an annual increase of three to six percent in ampicillin-resistant strains of *Hemophilus* and in some areas this is reportedly as high as a total of 38 percent resistance.

In the life-threatening diseases such as meningitis, bacteremia, and epiglottitis one cannot afford trials of the formerly reliant ampicillin. The current concensus is that chloramphenicol should be included in the initial treatment as its side effects are rare and worth the risk in these life-threatening situations. In otitis media if there is not a good response in 36 hours, then there are several alternatives. These would include erythromycin, sulfa, and cefaclor.

This is a prime example of an old organism developing a resistance to a tried and true antibiotic. It emphasizes the need for testing for the organism as well as its sensitivity and also the necessity of physicians keeping abreast of these subtle changes in medicine.—VSF

Nine-digit disaster

THE UNITED STATES Postal Service apparently is determined to foist upon its patrons the nine-digit zip code.

Judging by my own past experience, the postal service has not been able to keep track of its present five-digit system. For a time I kept a stack of first class mail envelopes that, although properly zip coded, had not only been sent over various parts of the state but also from coast to coast before at long last arriving on my desk.

The expense involved in changing all the mailing addresses for the *Wisconsin Medical Journal* and the mailing list for the State Medical Society would be considerable. For a large publication or the pharmaceutical companies with extensive mailing lists, the expense will be tremendous. Also, physicians seem to move frequently, requiring changes of address.

The editor of the *Farmers Almanac* says that "a nine-digit zip will drive people crazy. It is preposterous, ridiculous, and it would be the worst thing that has happened since Mt St Helens erupted."

And to top it off, at a time of high domestic unemployment and a mounting trade deficit, the United States Postal Service is spending hundreds of millions, perhaps billions, of dollars to buy the new mail sorting machines overseas. This equipment would be necessary to implement the already controversial nine-digit zip code.—VSF ■

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As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation, reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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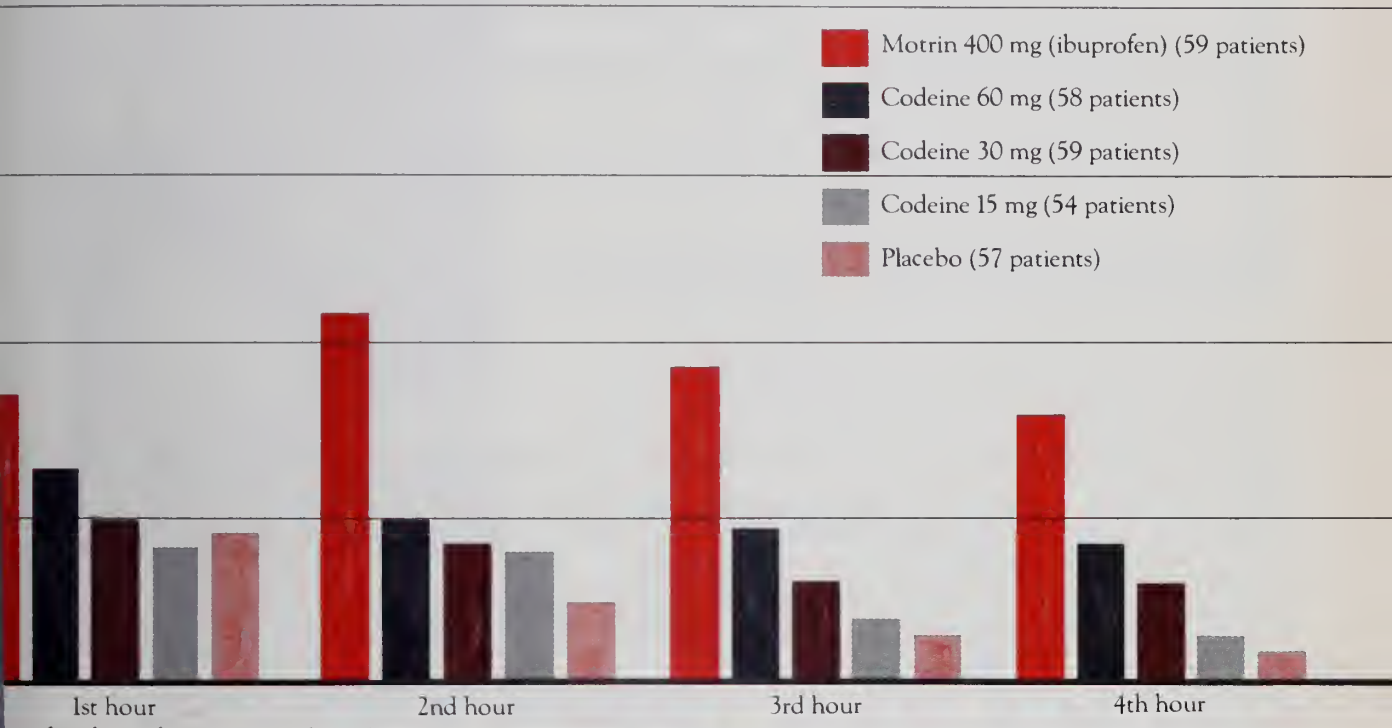

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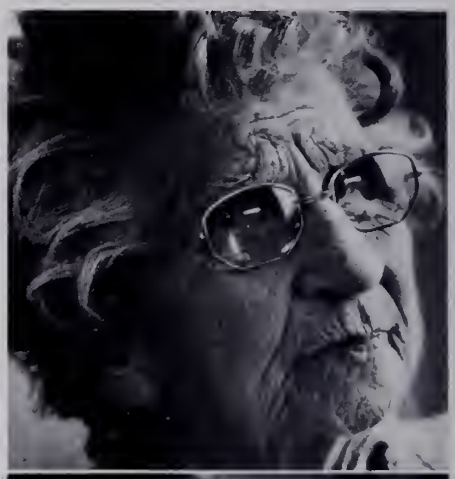

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Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

The HMO— caveat emptor?

OUR PRESIDENT, Dr Russell F Lewis, gave an excellent discussion of the HMO recently (*Wisconsin Medical Journal* 79:6, Sept 1980). He emphasized the many advantages of an HMO and pointed out who supports them and why. He has had a great deal more experience with HMO than I have, and his discussion seems reasonable and fair except for one very important consideration which I would like to emphasize.

Recently, subsequent to a major anteroseptal infarction, a sociologist was found on cardiac catheterization to have complete occlusion of the left anterior descending coronary artery with a ventricular aneurysm and disease in his remaining vessels. Myocardial revascularization was recommended and done; and he did well for some time but angina, dyspnea, and evidence of failure eventually returned. In the meantime he had joined a distant prepaid medical care program. After examination a physician told him that nothing more could be done. When he called me long distance to discuss this matter, I suggested repeat cardiac catheterization to determine the status of the ventricle, the valves, the coronary arteries, and the grafts in the hope that some remedial problem might be found. He told me that it could not be done in the prepaid group to which he belonged, that his doctor would not send him elsewhere to have it done, and that he did not know what to do. Since sociologists have been very interested in health maintenance organizations and written extensively about them, I asked him: "If you wished to receive the best possible medical care for yourself, would you approach a physician you do not know with the following proposition? I will give you $1000 if you will provide me with all of the medical care I need in the course of the next year. You may keep what you do not spend in caring for me." Among us physicians, who would make such a bargain for service with an unknown auto mechanic, grocer, or lawyer? There was a long pause at the other end of the phone and the sociologist answered, "Perhaps I had better get back into the main stream of medical care."

When a physician enters an HMO, he effectively becomes a partner in a financial venture which guarantees to render care for a fixed amount and for a fixed time interval. Life and people are imperfect. Medicine is full of dilemmas and as Hippocrates stated, "decision is difficult." It is not guaranteed to make decisions more easy or to weigh them in the favor of the patient when a physician considers that every diagnostic or therapeutic measure which he orders costs his HMO and himself money, and everything he does not order potentially increases his income. Such a proposition could easily cause the "small still voice" to whisper "90% of patients will get well no matter what you do—if you don't do too much."

Third-party payers very understandably welcome the physician into an HMO arrangement in the confident expectation that he will be more careful about how he spends money for patient care. The public accepts the idea happily because their confidence in the physician is so great they believe he will give them good care no matter what the cost. But will he when *each* decision to do something positive potentially costs him money? No matter how ethical a physician is, I see no way that this dilemma can be avoided except by avoiding the HMO. It is true that at the present time physicians profit from obtaining additional studies, x-rays and procedures, and I see no simple way to avoid this, but at least the profit motive in this case tends to provide more information concerning patients rather than less and tends to work toward better medical care rather than toward less supervision and less care.

There may be ways in which the profit motive may be diluted or disguised from the physician so that he will not see that each additional order he writes directly reduces his income. In at least one clinic the physician is not told whether a patient is a member of the local HMO. But this arrangement seems a clear admission of the presence of the problem. Perhaps HMOs can be useful if such schemes can be successful without subsidies from tax dollars. (Federal support for a local HMO provides subsidized medical care for a few at the expense of many.) At present, the course of incorporating the physician's profit motive into reducing the cost of medical care and that of rationing medical care may run perilously close together.

—George G Rowe, MD
Madison, Wisconsin ■

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Scientific Medicine

REFER TO—Katz M and Roehl J: Management of thoracic outlet syndrome in a community hospital. *Wisconsin Med J* 79:19-20 (Nov) 1980

KEY WORDS—Thoracic outlet syndrome, Raynaud's phenomenon, neurologic disease, vascular disease

Management of thoracic outlet syndrome in a community hospital

Mayer Katz, MD and **John Roehl, PA**
Beloit, Wisconsin

BETWEEN AUGUST 1976 and January 1980, 27 patients with thoracic outlet syndrome were treated at Beloit Memorial Hospital. Eleven were operated upon and 16 were treated conservatively.

DESCRIPTION OF SYNDROME. Thoracic outlet syndrome is an upper extremity disease caused by compression of the brachial plexus, subclavian artery, or vein.[1] Presenting symptoms, therefore, may be neurologic or vascular. Pain, paresthesias, numbness, or weakness occur in the upper extremity and may radiate to the hand or neck. Arterial symptoms include pallor and coldness of the hand. Venous compression results in edema, cyanosis, and venous engorgement. All of these may be exacerbated by exercise, especially above the level of the shoulder.

Unilateral Raynaud's phenomenon; *ie,* triphasic hand or finger color changes associated with numbness or coldness, suggests serious vascular pathology.

Bouhoutsos, et al,[2] described 42 such patients with thoracic outlet syndrome, most of whom had subclavian stenosis—often associated with a post-stenotic dilation or aneurysm. Mural clot within the aneurysm gave rise to recurrent emboli occluding smaller distal vessels and producing unilateral Raynaud's phenomenon.

The most frequent cause of unilateral Raynaud's phenomenon in thoracic outlet syndrome patients is a cervical rib causing subclavian stenosis and a post-stenotic aneurysm.[2] However, the other causes of thoracic outlet syndrome described so completely by Roos[1] may also produce arterial pathology; *ie,* muscular and fascial bands constricting in the thoracic outlet.

Short[3] described 16 symptomatic patients of 21 with cervical ribs. Fifteen of 21 patients had associated abnormal subclavian arteries. It is usually the anterior knob-like cartilaginous end of rib that adjoins the first rib which compresses the subclavian artery.

CLINICAL MANAGEMENT. The patients with significant symptoms associated with cervical ribs or other bony abnormalities of the thoracic outlet had two-position subclavian angiography followed by surgery. Three patients had cervical rib resections, one done bilaterally and another cervical rib resection combined with subclavian aneurysmectomy. *Illustrative case:* A 22-year-old female presented with a tender mass in the left neck and bilateral cervical ribs. Angiograms showed a left subclavian aneurysm.

The subclavian aneurysmectomy was done by the method described by Pierrandozzi.[4] Using simultaneous supra- and infraclavicular incision, the subclavian and axillary arteries were exposed. First, the cervical rib and its cartilaginous exostosis were resected, then the aneurysm itself was resected. The saphenous vein graft was placed in a retroclavicular tunnel.

The other patients with neurovascular compression (*ie,* those with thoracic outlet syndrome but without bony abnormalities) had a three-week course of physical therapy, consisting of shoulder girdle strengthening exercise (Fig 1). Twenty-four patients were sent to physical therapy (Fig 2). Eight improved with physical therapy and 12 did not change or worsened. These 12 had further evaluation

Presented before the Wisconsin Surgical Society at the Annual Meeting of the State Medical Society of Wisconsin, March 29, 1980, Milwaukee, Wisconsin. Reprint requests to: Mayer Katz, MD, 1905 Huebbe Parkway, Beloit, Wis 53511 (phone: 608/364-2200). Copyright 1980 by the State Medical Society of Wisconsin.

Figure 1—Clinical management of thoracic outlet syndrome

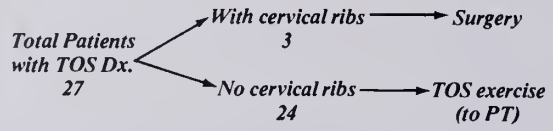
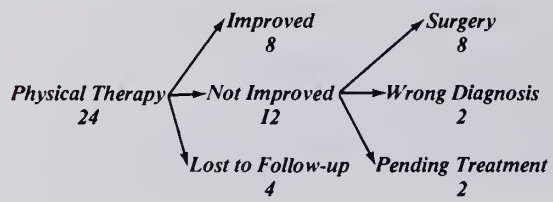


Figure 2—Patients sent to physical therapy



and invasive testing including electromyography and angiography. Two patients had been incorrectly diagnosed as thoracic outlet syndrome. One had a rotator cuff tendonitis and the other had cervical disc disease. Both later benefited from more appropriate therapy.

Eight patients were felt to have thoracic outlet syndrome from nonbony abnormalities (such as those described by Roos[1]). These patients had transaxillary first rib resections. Two were done bilaterally (Table 1).

RESULTS. Out of the entire group of 11 patients having either cervical rib or first rib resection there was no mortality. Morbidity included one pneumonia and two pneumothoraces. These are easily managed while still in the operating room.

There were two patients with neurologic sequelae of these procedures. One was an ulnar hypoesthesia that cleared completely in one month, the second was a mild intermittent brachial neuritis in the patient with the subclavian aneurysm (Table 2).

The time between surgery and follow-up interview in the operated patients varied between 3 and 42 months. Of the total of 11 patients, 8 had complete and 3 had partial relief of symptoms. None had worsened. The thoracic outlet syndrome was work-related in six patients. The type of work involved was usually an overhead type of job, typically on an assembly line. All of these improved and returned to work following surgery.

DISCUSSION. We have found the diagnostic tests described by Roos[1] helpful. These include:

1. The elevated arm exercise test.
2. Tenderness to pressure over the brachial plexus.
3. Hypoesthesia in the C8 - T1 dermatomes.

Table 1—Surgery

Cervical rib resections	3
Cervical rib resection and subclavian aneurysmectomy	1
Transaxillary first rib resections	10

Table 2—Results of surgery

Symptomatic relief of the total of 11 patients with either cervical or first rib resection

Complete	8
Partial	3
Worsened	0
MORTALITY	0
MORBIDITY	
Pneumonia	1
Pneumothoraces	2
Neurologic	2

1) Ulnar hypesthesia clear in one month.
2) Mild neuritic pain in patient with subclavian aneurysm.

4. Weakness of the triceps, interosseous, and grip.

Electromyography (EMG) has not been helpful.

We now limit angiography to those patients with cervical ribs, other bony abnormalities, and those patients with primarily vascular symptoms such as unilateral Raynaud's phenomenon. Many normal patients show angiocompression on subclavian arteriograms in a "stressed" position; *ie,* abduction and external rotation. Therefore, it is of limited use in the patients without vascular symptoms or bony abnormalities.[1,5,6]

Operative aids that we have found essential are:

1. The specially designed instruments—extra long ronguers, brachial plexus root retractors, and long right angle rib shears.
2. The fiberoptic head lamp.
3. The excellent technical descriptions of Schein and Roos.

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REFER TO—Bingham WF, Beguin EA, Ramirez-Lassepas M: Moyamoya disease in pregnancy. *Wisconsin Med J* 79:21-25 (Nov) 1980

KEY WORDS—Cerebral hemorrhage, cerebral ischemia, moyamoya disease

Moyamoya disease in pregnancy

William F Bingham, MD and **Everett A Beguin, MD,** La Crosse, Wisconsin
and **Manuel Ramirez-Lassepas, MD,** Minneapolis, Minnesota

THE UNCOMPLICATED pregnancy, delivery, and puerperium of a 24-year-old woman with well-documented moyamoya disease are described. The risk of stroke may be compounded for the pregnant moyamoya patient because of the fluctuations in blood pressure which normally take place. To minimize this risk, blood pressure should be carefully monitored. An arterial catheter is recommended during the three stages of labor and the immediate postpartum period.

IN 1972 NISHIMOTO and Takeuchi[1] reported 111 cases of moyamoya disease from Japan. The incidence was slightly higher in females (66:45). Young persons were principally affected, 55 of their patients being 10 years of age or less. Another 20 patients were between the ages of 11 and 20. Despite the predilection of moyamoya disease for young females and the increasing frequency of recognition in all corners of the world, there are no published accounts of pregnant moyamoya patients. The following is a case report of a patient with well-documented moyamoya disease who successfully completed pregnancy without complication.

CASE REPORT. A 20-year-old, right-handed, white woman was admitted to St Paul-Ramsey Hospital on July 9, 1973 because of ten days of left-sided weakness and paresthesias. She also complained of throbbing right-sided headache. She denied taking birth control pills. She had never been pregnant.

There was no history of local or systemic infection, heart disease, drug abuse, or migraine. Two years before the patient had undergone an uncomplicated thoracic laminectomy and insertion of Harrington rods because of progressive scoliosis.

Family history included an aunt who had one or two "strokes" associated with childbirth at age 25 and another aunt who had a stroke at age 35.

Pertinent physical findings were a mild left hemiparesis and hemisensory loss and a "classical, right, nondominant, parietal lobe syndrome." There were no carotid bruits or heart murmurs. The residual scoliosis was minimal. The remainder of the physical examination was unremarkable.

Skull films were within normal limits. Her erythrocyte sedimentation rate was 6 mm/hr. A test for antinuclear antibodies was negative. Serum and cerebrospinal fluid tests for syphilis were nonreactive. An electroencephalogram showed "diffuse, right hemispheric slowing." Transfemoral cerebral angiography revealed the origins of the carotid and vertebral arteries to be normal, but there was marked narrowing of the cavernous portion of the right internal carotid artery (Fig 1). Serial lumbar punctures demonstrated a persistent lymphocytosis.

On July 12, three days after admission, the cerebrospinal fluid contained 27 white blood cells per cu mm (93% mononuclear and 7% polymorphonuclear leukocytes). By July 30 there were 11 white blood cells per cu mm, all of which were mononuclear leukocytes. The cerebrospinal fluid (CSF) protein was always within normal limits. No microorganisms were recovered from any of the CSF cultures.

The patient's neurologic condition waxed and waned for the first few weeks. She was treated with corticosteroids and low molecular weight dextran without obvious benefit. She was placed on long-term anticoagulant therapy with warfarin. Her condition slowly improved, and at discharge on August 18 she had a very mild left hemiparesis and hemisensory loss. The left myotatic reflexes were hyperactive. She had five to six beats of left ankle clonus and a left Babinski sign.

She was readmitted two months later, on October 15, because of pregnancy for which she underwent a therapeutic abortion by suction curettage. Her neurologic condition was unchanged. A repeat spinal tap showed 12 white blood cells per cu mm (100% mononuclear leukocytes). She was discharged October 18.

The patient was readmitted on January 26, 1974 for elective cerebral angiography. Her neurologic condition was stable. Arteriography showed a complete occlusion of the right vertebral artery distal to the origin of the posterior inferior cerebellar artery and moderate narrowing of the intracranial left vertebral artery (Fig 3) and of both intracranial internal carotid arteries. An intrauterine device was inserted which re-

From the Departments of Neurosurgery (WFB) and Obstetrics and Gynecology (EAB), Gundersen Clinic, Ltd and La Crosse Lutheran Hospital, La Crosse, Wisconsin; and the Department of Neurology (MR-L), St Paul-Ramsey Hospital, St Paul, Minnesota. Publication support provided. Reprint requests to: William F Bingham, MD, 140 Grandview Ave, Waterbury, Conn 06708 (phone: 203/573-1423). Copyright 1980 by the State Medical Society of Wisconsin.

Figure 1—Right common carotid arteriogram performed roughly two weeks after the sudden onset of left hemiparesis, hemisensory loss and "classical, right nondominant, parietal lobe syndrome." There is a high grade stenosis of the cavernous portion of the internal carotid artery (light arrow).

mained until just prior to the present pregnancy.

Because of the abrupt onset of left hand weakness and clumsiness the day before, the patient was readmitted on April 28. She had a slight left facial weakness but good strength in all four limbs. The myotatic reflexes remained more active on the left. Sensory examination was normal except for mild difficulty with stereognosis. Erythrocyte sedimentation rate was 15 mm/hr. The lumbar cerebrospinal fluid was now normal.

Her condition improved dramatically, and it was suspected that hospitalization had been precipitated by stressful circumstances at home. She was discharged May 2. Her neurologic condition remained stable, and warfarin was discontinued in 1976.

The patient was readmitted on two additional occasions for elective cerebral angiography. Each four-vessel study showed continued subclinical progression of her disease (Figs 2 and 4). A repeat electroencephalogram in February 1977 was "mildly to moderately abnormal because of diffuse slowing, asymmetry of activity, with reduction of amplitude in the temporal region as well as occasional bursts of rhythmic bifrontal delta, more prominent on the right."

The patient moved from St Paul to Winona, Minnesota, and in summer 1978 she presented at the Gundersen Clinic in the first trimester of pregnancy. She was followed in the High Risk Obstetrical and Neurosurgical Clinics. She denied any interim neurologic problems.

Her blood pressure was 110/56 mmHg. The carotid and superficial temporal pulses were bounding bilaterally. There was no conspicuous facial weakness. With a hand grip dynamometer she could squeeze 25 kg on the right and 20 on the left. Fine finger movements involving the left hand seemed clumsy. Muscle tone was slightly increased in the left upper and lower limbs. The muscle stretch reflexes were more brisk on the left. There was a trace of left ankle clonus, but no Babinski sign could be elicited. Sensory examination, including both tactile and visual extinction testing, was within normal limits.

Her pregnancy proceeded uneventfully. She was admitted on November 27 because of prematurely ruptured membranes. Later that evening she went into spontaneous active labor. Epidural anesthesia was attempted unsuccessfully. At this point labor proceeded rapidly and uneventfully to complete cervical dilatation. She was taken to the delivery room and, under pudendal anesthesia, a low mid-forceps delivery was accomplished with only occasional involuntary pushing on her part. A male child weighing 3.0 kg with Apgar scores of 3 and 9 was delivered.

Shortly after admission the right radial artery was catheterized for blood pressure monitoring. During the first stage of labor, the systolic pressure ranged from 96 to 124 mmHg. During the second stage, it rose to the 140-150 range. On a few occasions associated with involuntary pushing the systolic pressure rose as high as 180. During the third stage and episiotomy repair, it returned to resting levels. The catheter was removed two hours postpartum, although blood pressure continued to be carefully watched throughout the remainder of her hospital stay. An electroencephalogram on the third postpartum day was normal. Mother and child were discharged December 3.

The patient has had no subsequent neurologic or obstetric problems. Ocular pneumoplethysmography (OPG-Gee) performed March 7, 1979 revealed an ophthalmic artery pressure (OAP) of 89 mmHg OD and 78 OS. The concomitant systemic blood pressure (cuff systolic) was 120 mmHg.

DISCUSSION. In their earlier review of moyamoya disease, Nishimoto and Takeuchi[2] found that moyamoya patients under 21 years of age usually presented with a sudden hemiparesis that quickly disappeared but often returned. They became symptomatic because of cerebral ischemia; and as their collateral circulations grew more

competent, their neurologic deficits abated. Older patients in their series generally presented with subarachnoid hemorrhage. This was felt to be due to rupture of the fine, thin-walled, collateral vasculature which develops in response to large vessel stenosis and occlusion.

Since in otherwise normal individuals hypotension can cause or worsen cerebral ischemia, and even result in infarction, and hypertension can precipitate cerebral hemorrhage, these extremes appear particularly hazardous for patients with moyamoya disease. Furthermore, while surgery in healthy persons is associated with an increased incidence of stroke,[3] that risk may be compounded for the pregnant moyamoya patient.

In a few case reports pregnancy did not seem to precipitate moyamoya disease. Iivanainen, Vuolio, and Halonen's[4] second case had two uncomplicated pregnancies; she later became symptomatic with moyamoya disease at age 48. A 32-year-old patient reported by Sogaard and Jorgensen[5] had three uneventful pregnancies and one miscarriage at the fifth month. She then developed neurologic symptoms and was diagnosed as having moyamoya disease while taking oral contraceptives. The patient reported by Mastri, Silverstein, Gold, et al[6] also had three normal pregnancies before developing clinical manifestations of moyamoya disease while taking oral contraceptives at age 30.

Iivanainen, Vuolio and Halonen,[4] Sogaard and Jorgensen,[5] Mastri, Silverstein, Gold, et al,[6] and Boone and Sampson[7] have reported the onset of moyamoya disease in patients taking oral contraceptives. Since intimal thickening is one of the vascular effects of oral contraceptive therapy[8] and also one of the very few pathologic findings of moyamoya disease,[6] we advised our patient against this means of contraception.

Figure 2—Right common carotid arteriogram performed almost two years later. At this point the patient had been neurologically stable for one year. The high grade stenosis has progressed proximally to include almost the entire right internal carotid artery (dark arrows). Several transdural external-internal anastomoses have formed in the interim.

In his exhaustive review of the natural history of subarachnoid hemorrhage, Locksley[9] found that roughly one-third of all subarachnoid hemorrhage was associated with some form of bearing down—lifting, bending, defecation, coitus, coughing, urination, parturition. Although only 1 percent (46 of 4,604) of his patients sustained a subarachnoid hemorrhage during labor and delivery, we were concerned about our patient in view of the predilection of adult moyamoya patients for subarachnoid hemorrhage.

Presumably intracranial bleeding, principally subarachnoid but also intracerebral and subdural, occurs because of the thinness and friability of the anastomotic vessels, particularly those constituting the moyamoya. Subarachnoid hemorrhage can take place at any time during or after pregnancy. Arteriovenous malformations typically rupture during the second trimester whereas aneurysmal bleeding is most common during the third trimester.[3]

When our patient presented for obstetrical care, three prominent Japanese neurosurgeons were contacted by mail. Only Nishimoto

Figure 3—Left vertebral arteriogram performed seven months after the initial attack. The vessel is moderately narrowed near its junction with the right vertebral. A moyamoya is beginning to opacify about the basilar bifurcation.

(personal communication) claimed any experience with moyamoya disease in pregnancy. Two patients in his clinic did not require any blood pressure control during their pregnancies. Both babies were delivered by cesarean section. One child had a cleft lip. Nishimoto also commented upon a third patient who delivered elsewhere who sustained "some symptoms suggesting subarachnoid hemorrhage in her postpartum period, from which she recovered well." He recommended that blood pressure be carefully followed during pregnancy and actively regulated if hypertension proved to be a problem. He further advised delivery by cesarean section to avoid hyperventilation-induced cerebral ischemia and hypertension provoked by active labor.

Our approach was to follow the patient's blood pressure carefully throughout pregnancy and to regard her from an obstetrical standpoint as one would a pregnant cardiac patient. We wished to allow labor and delivery to proceed as naturally as possible and to intervene actively only if required. La Maze instruction was felt to be an important means of reducing anxiety, hyperventilation and unnecessary straining.

On the day of admission a direct arterial line was established for blood pressure monitoring. We planned to use ephedrine or volume replacement for hypotension. Hydralazine was kept in readiness for hypertension. Neither medication was required. The arterial catheter greatly facilitated blood pressure monitoring and enabled the obstetrical team to be aware of even the slightest fluctuations.

Throughout labor the patient's neurologic condition was carefully assessed. Although considered, electroencephalographic monitoring was not performed. Seizures, secondary to ischemia, infarction, or hemorrhage, were also anticipated as well as secondary cerebral edema. Treatment of the latter is controversial since corticosteroids, diuretics and/or osmotic agents have not been proven conclusively to be of value for ischemic brain edema.[10]

Our patient had never smoked cigarettes, so it was not necessary to interdict smoking. Finally, it was agreed not to suppress lactation with hormonal agents because of possible adverse cerebrovascular effects. The patient elected to breast feed. Although presently practicing contraception with an intrauterine device, she is also contemplating a second pregnancy.

There are three atypical features of our moyamoya patient: the scoliosis, CSF pleocytosis, and site of carotid stenosis. The combination of moyamoya disease and scoliosis is probably coincidental. The transient CSF pleocytosis remains unexplained.

Although moyamoya disease usually affects the supraclinoid portion of the carotid artery and often the proximal branches of the anterior and middle cerebral arteries, the so-called carotid fork of Suzuki and Takaku,[11] involvement of the cavernous carotid is not rare. Handa and Handa[12] reported

six cases. All were children. Five had occlusions and one had stenosis of the carotid artery prior to the take-off of the ophthalmic artery. One adult patient in their series had a complete occlusion of the cervical portion of the internal carotid artery.

The ease with which our patient proceeded through pregnancy, labor, and the puerperium may be due to the fact that she has a burnt-out or end-stage form of moyamoya disease. Suzuki and Takaku[11] described six stages, the final one consisting of a complete takeover of the cerebral circulation by the external carotid system through an elaborate network of external-internal anastomoses. At this point the internal carotid artery is completely occluded, and the external-internal anastomotic network is so competent that there is no need for the moyamoya which actually disappears.

Although serial angiography from 1973 to 1977 did not document end-stage moyamoya disease in our patient, it did reveal a steadily increasing collateral network (Figs 1-4). No cerebral angiography was performed during her confinement, but it is conceivable that she had passed into the final stage and that her cerebral circulation was at less risk during this pregnancy than it would have been earlier in a more active stage.

The patient's current OPG findings are consistent with adequate collateral flow to the right eye and cerebral hemisphere but chronic ischemia to the left globe and hemicerebrum.[13]

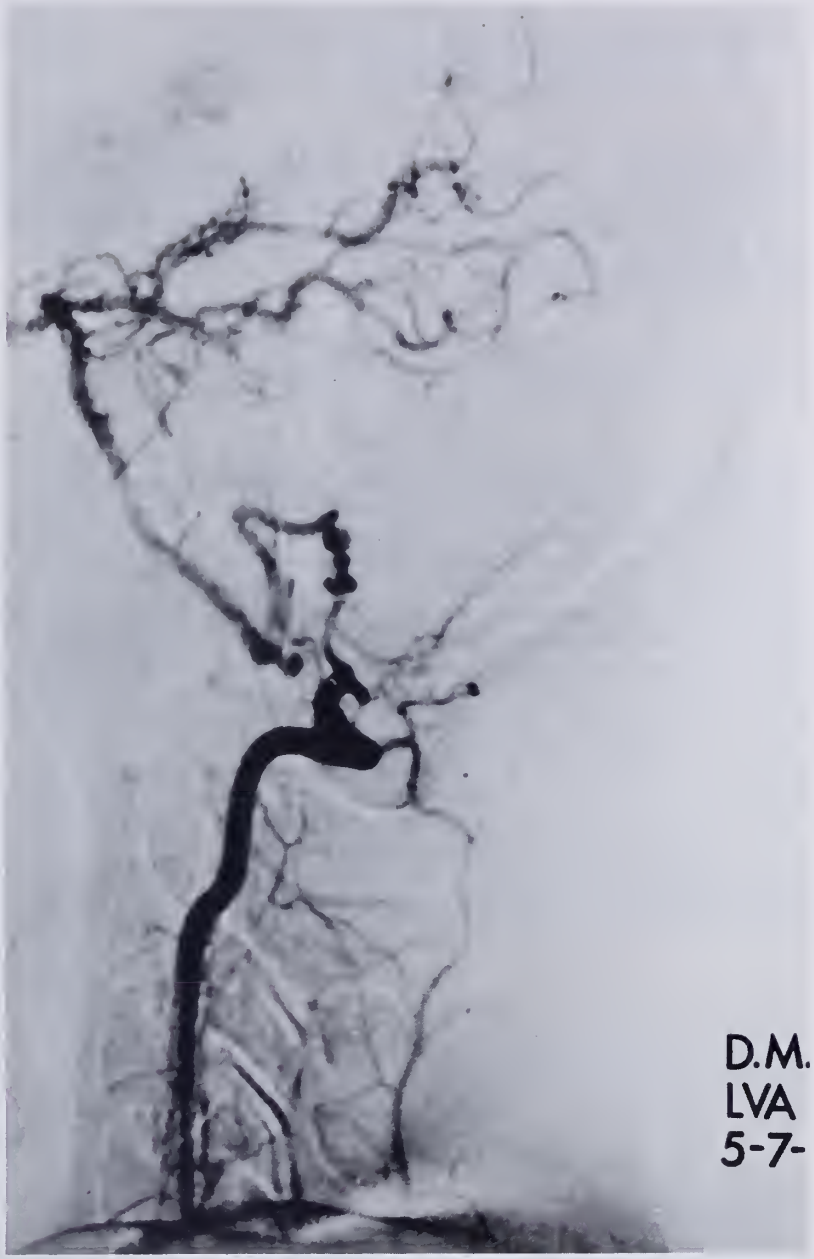

Figure 4—Left vertebral arteriogram demonstrating distal interim occlusion with collateral filling of the basilar artery via a large corkscrew muscular branch.

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REFER TO—Larratt K, Helstad A, Davis JP, LaVenture M: Sporadic cases of Legionnaires' disease in Wisconsin: Epidemiologic and clinical characteristics. *Wisconsin Med J* 79:26-28 (Nov) 1980

KEY WORDS—Legionnaires' disease, *Legionella pneumophila*, epidemiologic study

Sporadic cases of Legionnaires' disease in Wisconsin: Epidemiologic and clinical characteristics

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Between November 1, 1976 and May 1, 1979 there were 28 confirmed cases of Legionnaires' disease in Wisconsin. Twenty-four cases were serologically diagnosed by indirect immunofluorescence on paired serum specimens; four cases were confirmed by direct immunofluorescence on lung tissue. All but one of the cases were considered to be sporadic, with no apparent temporal or geographic clustering. The male-to-female ratio was 3.7:1; the mean age was 59 years, and 68% of the 28 cases had onset dates between July and October. Pneumonia was documented in 96% of the cases. Major symptoms included fever (93%) often reaching 104-105F, a nonproductive cough (75%), and chills (55%). Ninety-six percent of the patients were hospitalized. Seven (25%) of the 28 patients died. Potential risk factors at date of onset of illness included cigarette smoking (60%), ex-smoker (18%), chronic bronchitis (27%), cancer (21%), diabetes mellitus (29%), and use of corticosteroids (20%). One patient had received a renal transplant.

THE TERM "Legionnaires' disease" (LD) is currently used to refer to illness resulting from infection with a strain of the bacterium *Legionella pneumophila* that was associated with a 1976 outbreak of atypical pneumonia in Philadelphia or from infection with another strain of the same organism.[1,2] LD most commonly presents as a form of acute pneumonia.[3] The onset of this syndrome begins two to ten days after exposure to *L. pneumophila*. In a typical case, the early symptoms include malaise, myalgias, and mild headache; followed within 24 hours by rapidly rising fever and chills. Temperatures commonly exceed 102F. A nonproductive cough is common at sometime during the illness; the cough is occasionally productive. Associated manifestations may include chest pain, abdominal pain, diarrhea, other gastrointestinal symptoms, impaired renal function, and confusion.

LD may occur in large common-source outbreaks, as a series of cases in areas of apparently high endemicity, or in sporadic cases without apparent temporal or geographic clustering.[4]

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MATERIALS AND METHODS. *Source of cases.* Cases consisted of patients who had specimens referred to the Center for Disease Control (CDC) or the Wisconsin State Laboratory of Hygiene (SLH) between November 1, 1976 and May 1, 1979 and were diagnosed as having evidence of LD based on laboratory criteria. Cases that were confirmed using an indirect immunofluorescence test (IFA) demonstrated a fourfold or greater rise in antibody titer to a reciprocal titer of $\geq$1:128 on paired sera. Cases confirmed by a direct immunofluorescence test (DFA) had the organism demonstrated in lung tissue. In contrast, a titer of $\geq$1:256 as measured by IFA for a single serum specimen was considered presumptive evidence of infection with *L. pneumophila* at some undetermined time. Fourteen cases with only presumptive evidence of infection were deleted from the study.

Source of data. The data presented were collected from two sources: (1) CDC standardized questionnaires were sent to all referring physicians who had patients with a confirmed or presumptive diagnosis of LD. Seventy-two percent of these questionnaires were completed and returned. This information was supplemented by (2) records maintained by SLH from specimen referral sheets. Physicians and/or hospitals were required to specify age and sex of the patient, illness onset date, specimen collection dates, and clinical syndrome at the time specimens were submitted.

RESULTS. During the study interval, 28 cases of LD were confirmed at the SLH or the CDC; 24 cases were confirmed by IFA and 4 by DFA. One patient was an out-of-state resident hospitalized in Wisconsin.

Distribution of cases. The annual incidence rate for LD in Wisconsin was 0.24 cases per 100,000 population during the 30-month study interval.

Twenty-seven cases were considered sporadic, with no apparent temporal or geographic clustering seen (Table 1). One case was possibly associated with an outbreak of LD in Bloomington, Indiana, an area of documented hyperendemicity for LD.[5] That person had visited Indiana University within two weeks prior to onset of illness.

Table 1—Residence of confirmed Legionnaires' disease cases in Wisconsin, by county/November 1, 1976-May 1, 1979

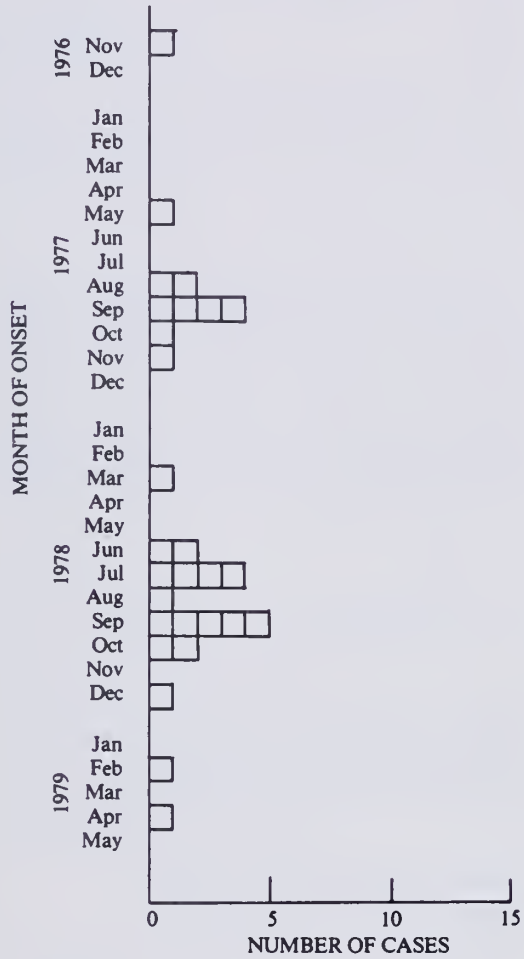
County	*Number of cases**
Dane	2
Jackson	1
Jefferson	2
Kenosha	2
La Crosse	1
Marathon	2
Marquette	1
Milwaukee	8
Monroe	1
Racine	1
Rock	1
Sauk	1
Sheboygan	1
Trempealeau	1
Vernon	1
Winnebago	1

*One out-of-state case not listed.

Table 2—Clinical features of confirmed Legionnaires' disease cases in Wisconsin/November 1, 1976-May 1, 1979

Clinical features	*Present*	*(%)*	*Absent*	*Data not available*
Pneumonia-x-ray diagnosed	23	(96)	1	4
Fever	25	(93)	2	1
Cough-nonproductive	18	(75)	6	4
Chills	12	(55)	10	6
GI	9	(39)	14	5
Chest pain	8	(38)	13	7
Malaise	8	(36)	14	6
Headache	8	(35)	15	5
Myalgias	7	(33)	14	7
Confusion	7	(33)	14	7
Dyspnea	7	(32)	15	6
Sputum production	2	(10)	19	7

Figure 1—Cases of confirmed Legionnaires' disease in Wisconsin by month of onset of illness: November 1, 1976-May 1, 1979



Age and sex distribution. The age range in patients was 29 to 82 years. The mean age was 62 years for males, 56 years for females; and 59 years overall. A 3.7:1 male-to-female ratio was observed.

Seasonal distribution. Figure 1 depicts the chronologic distribution of LD in Wisconsin. The peak month of onset was September; 68% of the cases had onset between July and October.

Clinical features. Pneumonia was radiographically confirmed in 96% of the cases (Table 2). Major symptoms included fever (93%), a nonproductive cough (75%), and chills (55%). Approximately 33% had evidence of one or more of the following: malaise, myalgias, chest pain, confusion, gastrointestinal symptoms (nausea, vomiting, diarrhea, or abdominal pain), dyspnea, and headache.

A variety of potential risk factors has been reported in association with LD.[3] Risk factors noted among Wisconsin cases included current cigarette smoking (60%), ex-smoking (18%), chronic bronchitis (27%), cancer (21%), diabetes mellitus (29%), and use of corticosteroids (20%). One patient had received a renal transplant. Ninety-six percent of the patients were hospitalized and 40% required ventilatory assistance. Seven patients died (25% mortality).

DISCUSSION. Since the isolation of *L. pneumophila* following the large Philadelphia outbreak in July 1976, extensive observations of the features of LD have been made.[6,7] The epidemiologic and clinical findings reported in this paper are similar to previously published findings for the entire United States.[3,6,8]

All cases in our series differ clinically from the syndrome of "Pontiac fever" (PF), a mild illness of acute onset and short duration consisting of fever,

myalgia, and headache associated with *L. pneumophila.*[9] In a 1968 outbreak of 144 cases of PF, there was no instance of pneumonia and no deaths.[9] Among sporadic cases of diagnosed LD, the recognition of "Pontiac fever-like" disease is uncommon.

A late summer-early fall seasonality noted among the sporadic Wisconsin LD cases has been apparent in most of the described outbreaks.[10] A period of several years observation will be necessary to determine if this seasonal trend continues. Considerable circumstantial evidence[9-11] and some direct evidence[5,12] indicates that *L. pneumophila* is a common soil organism. The opportunity for soil organisms to become airborne and inhaled is increased during the summer and fall months. We would thus speculate a continuation of the observed seasonal pattern of LD.

Presently, based on clinical and laboratory data, erythromycin is the drug of choice in the treatment of LD.[13-17] The recommended dose has been 1.0 gm given every six hours; although in most cases 0.5 gm given every six hours has been sufficient. Because a laboratory diagnosis of LD may be delayed for several weeks, treatment should be initiated promptly on clinical and epidemiologic suspicion. While many patients respond dramatically to treatment, relapse or prolonged convalescence may occur if treatment is discontinued prior to completing a minimum 14-day course.

While rifampin demonstrates the greatest *in-vitro* and *in-vivo* antimicrobial activity against *L. pneumophila* among agents tested, data on its clinical efficacy in the treatment of LD are lacking. Because many bacterial species develop rapid resistance to rifampin, it should be reserved for use in the treatment of a patient with LD who is not responding satisfactorily to erythromycin.[3]

Therapeutic support measures such as mechanical ventilation including positive end-expiratory pressure, fluid management, and maintenance of blood pressure and organ perfusion with the use of fasoactive drugs are often required in the management of critically ill LD patients.[3]

In April 1978 the Conference of State and Territorial Epidemiologists agreed to make LD reportable for a three-year interval. The continued epidemiologic and laboratory study should provide valuable information about LD and *L. pneumophila* and may lead to a more rapid diagnosis, a more effective therapy, and methods of preventing LD.

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Abstracts

Presented at the Spring Meeting of the Wisconsin Neurological Society, May 9-10, 1980, Madison

Francis M Forster, MD, Madison, Program Chairman

Cerebral air embolism while scuba diving: case report

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A 24-year-old right-handed white female (certified for scuba diving in 1977 with experience of 30 to 50 dives) dived in the Carribbean on 11/05/79 to a depth of 100 feet and remained there for about 15 minutes. Shortly after surfacing she was nauseated and vomited; she also noted loss of central vision and a right hemiparesis with numbness of the right upper and lower limbs. The visual loss and the hemiparesis cleared up within 24 hours, but sensory impairment persisted, with tendon reflex asymmetry.

On return to Milwaukee, neurological examination nine days after the accident showed asymmetry of tendon reflexes, a right Babinski response, and mild sensory impairment in the right lower extremity. EEG on the ninth day after the accident showed excess posterior slow waves; these had disappeared on the follow-up EEG six weeks later.

Brain Stem Auditory Evoked Responses were somewhat unusual but considered within normal limits. The patient made a complete neurological recovery, except for slight sensory loss in the right lower limb. She returned to her full-time factory employment. ■

REFER TO—Mueller RG, Lang GE: Alcohol levels in emergency room patients. *Wisconsin Med J* 79:29-30 (Nov) 1980

KEY WORDS—Alcohol use, emergency room service

Alcohol levels in emergency room patients

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THE ASSOCIATION of alcohol with traffic and burn accidents in the home is known. Sixty-five percent of automobile drivers killed in traffic accidents in Wisconsin are under the influence of alcohol.[1] Sixty-one percent of burn patients have positive blood alcohol levels at the time of admission.[2] Fifty percent of those injured in snowmobile accidents,[3] 23% of those injured in home accidents,[4] and 56% of those injured in fights or assaults[4] involved alcohol.

The symptoms associated with elevated levels of alcohol range from slurred speech to muscular incoordination approaching paralysis to complete unconsciousness.[5] These symptoms of alcohol intoxication may mask other underlying processes, and it would be well to rule out coexistence of cerebral injuries, apoplexy, subdural hematoma, toxic delirium, uremia, diabetic coma, etc, with alcohol intoxication.[6] The simultaneous ingestion or administration of sedatives and other hypnotics may produce markedly deranged behavior and a confusing clinical picture.[7]

In view of the high percentages of alcohol involvement in "emergency" circumstances, it was decided to determine the degree of association of ethanol in the mix of patients observed in an urban hospital emergency room.

METHOD. Alcohol levels were performed on 97 adult (over 14 years) emergency room patients who had serum specimens submitted to the laboratory by the emergency room. These specimens were obtained for other chemical analyses requested by the emergency room physician. The analyses were performed in a five-week period in 1979 on a DuPont analyzer, which employs a modified alcohol dehydrogenase reagent system.

RESULTS. A histogram of the 97 alcohol levels observed can be seen in Figure 1. Previous reports[1,2] indicated that alcohol levels above 0.010% are positive. Table 1 indicates the frequency distribution of the positive levels observed.

Figure 1 indicates that of the total population (a) 71% of the patients in this series were negative for alcohol, (b) 27% had alcohol levels above 0.02% which is the threshold of impairment,[8] and (c) 20% had alcohol levels above 0.100%, which is the current limit for prima facie evidence of intoxication while operating a motor vehicle in Wisconsin. The incidence of alcohol levels in the range 0.050-0.300% are generally of the same order of magnitude as alcohol levels associated with burn patients. One surprise was the frequency of very high alcohol levels. Twelve percent of the patients in this study had alcohol levels greater than 0.20%, and 6% had alcohol levels greater than 0.300%.

Alcohol was correctly suspected by the physician in over 80% of the positives. However, 5 of the 28 positive blood alcohol levels observed were not requested by the attending physician. Two of these patients "smelled" of alcohol.

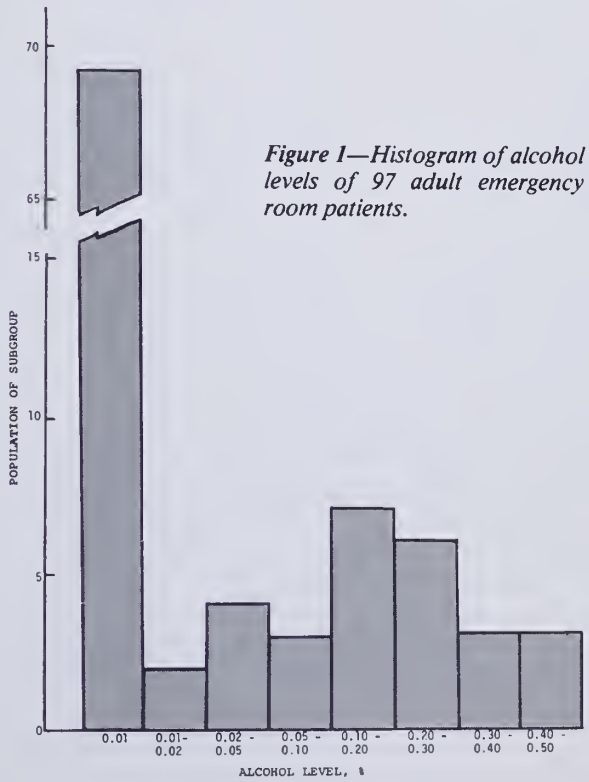

Figure 1—Histogram of alcohol levels of 97 adult emergency room patients.

From the Laboratory Service, St Mary's Hospital, Milwaukee, Wisconsin. Reprint requests to: Rudolph G Mueller, MS, St Mary's Hospital, PO Box 503, Milwaukee, Wis 53201 (phone: 414/289-7180). Copyright 1980 by the State Medical Society of Wisconsin.

The importance of timing in obtaining alcohol specimens was underscored by patient no. 0148; the alcohol level on arrival was 266 mg/dl, while four and one-half hours later it was 54 mg/dl. Incidentally, patient no. 0148 had been previously discharged from St Mary's Hospital earlier on the same day.

There were 25 women in the population of 97; only two of these were positive, with alcohol levels of 12 and 117 mg/dl. The incidence and severity of alcohol intoxication observed in this population were lower for women.

SUMMARY. This study indicates that 27% of the patients whose serum was tested had alcohol levels above the threshold of impairment, and 20% were legally intoxicated. The frequency distribution of alcohol levels observed here parallels that previously observed for burn patients in the range 0.050-0.300%. The incidence of alcohol levels greater than 0.300% is higher in these emergency room patients than expected from previously observed data.[2]

Table 1—Frequency distribution of 28 positive alcohol levels observed in 97 adult emergency room patients

Lab #	*Alcohol %*	*Alcohol ordered by physician +/-*	*Diagnosis; chart comments*
4957	0.012	+	Chronic alcoholism; 3 quarts/day.
3424	0.012	+	Chronic alcoholism, thyrotoxicosis, atrial fibrillation. Female.
2261	0.021	-	Abdominal pain for 4 days; drawn 1 hour after arrival.
1359	0.024	-	Post seizure; ETOH drawn 1 hour after arrival, Dilantin® = 8 mg/l.
1984	0.037	+	Burning pain, epigastrium, drinking heavily for past week.
3895	0.040	+	Burn admission, 2 drinks/day.
2481	0.055	-	Hypoxic encephalopathy.
5475	0.078	+	Atrial fibrillation, alcoholism; had been drinking "yesterday."
0124	0.098	+	Chronic pancreatitis; patient's birthday.
xxxx	0.110	-	"Beaten last night"; alcohol on breath, ETOH not ordered.
3412	0.117	+	Unconscious after drinking. Female.
4307	0.131	+	Head and neck pain; auto accident.
4766	0.151	+	Multiple lacerations and head trauma.
4739	0.181	+	R/O MI; past alcohol abuse; brought in from work.
2851	0.183	+	Headache; diabetic under control.
3922	0.198	+	Low abdominal pain for 24 hours.
4320	0.213	+	Head injury; laceration.
yyyy	0.244	+	Chest pain; long history of alcohol abuse.
2774	0.262	+	Acute alcohol intoxication; drug overdose.
3970	0.264	+	Head laceration.
0148	0.266	+	Found unconscious; previous basal skull fracture.
4735	0.274	-	Emphysema and asthma; "smells of alcohol" ETOH not ordered.
3866	0.327	+	Facial abrasion; fell down 15 stairs.
1862	0.334	+	Depressed.
4275	0.337	+	Beaten up.
2675	0.406	+	Acute alcohol intoxication.
2305	0.408	+	Contusion and abrasion on forehead; auto accident.
2096	0.408	+	Chronic pancreatitis, cirrhosis, chronic alcoholism.

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Abstracts

Presented at the Spring Meeting of the Wisconsin Neurological Society, May 9-10, 1980, Madison

Francis M Forster, MD, Madison, Program Chairman

Pattern-reversal visual evoked potentials and their relationship to retinal eccentricity

J Todd Meredith, MD, Madison, Wisconsin
Gastone G Celesia, MD, Madison, Wisconsin

The effect of stimulation of discrete areas of the retina on visual evoked potentials (VEP) was studied in 20 normal volunteers. The stimulus consisted of squares containing checks reversing at a frequency of 500 msec and back-projected to a 60 cm diameter hemispheric screen. Visual evoked potentials could be obtained with stimulation of the central retina from 0 to 2° with stimuli as small as 1° subtense and checks of 30 minutes of arc. No VEPs were ever obtained outside the 4° isopters with a 2° stimulus. VEP could, however, be elicited by increasing the size of the stimulus to 10° or larger.

These data suggest that scalp pattern-reversal VEPs are mostly the result of the stimulation of the central fovea. They further indicate that the receptive fields at the foveal region are as small as 1° while the receptive fields outside the first 2° isopters are 10° or larger. These findings agree with the estimation of the human cortical magnification factor by psychophysiological methods. ■

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CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS

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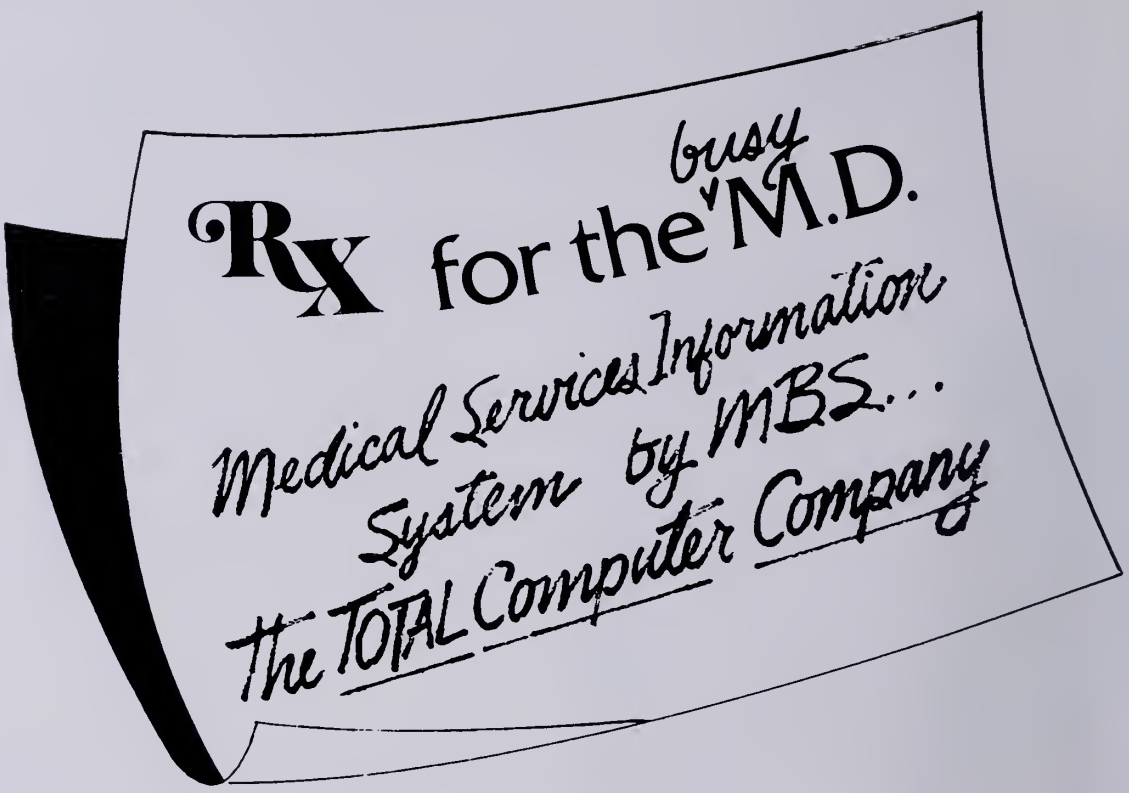

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Council meeting action: September 27

Women's health committee

The Council created a nine-member Committee on Women Physicians to be comprised of members from the former ad hoc committee on women's health—Doctors Patricia Stuff, Bonduel; Pauline Jackson, LaCrosse; Carl Eisenberg, Milwaukee; Kathryn Bemmann, Waukesha; and Sandra Osborn, Madison. The remaining members will be appointed in the near future.

Charges of the new committee will be: to serve as a liaison and women's advocate with other SMS commissions and committees; to enhance medical education opportunities for women; to promote medical education that is sensitive and responsive to women's healthcare needs, and to serve as a resource to the State Medical Society and other groups and individuals on women's health issues. The Council also approved several recommendations made by the committee including a recommendation that state, county and specialty societies actively seek to include women physicians in their committee structure.

Corporate visitation program

The Council approved a statewide corporate visitation program to begin before Christmas and continue throughout next year. Under the program, SMS officers will seek visits with chief executive officers of the major corporations and businesses in Wisconsin to discuss health issues affecting Wisconsin businesses.

Mediation and peer review

The Council agreed that the SMS Commission on Mediation and Peer Review would not provide consultation to third-party carriers on the appropriateness of fees. The Council's action does not prohibit the Commission from reviewing individual patient complaints involving the appropriateness of fees. The Council also agreed that the Commission continue its practice of reviewing the appropriateness of care upon referral from third parties, but that the Society seek reimbursement for such services from third parties.

Medical liability position paper

The Council approved an extensive medical liability position paper prepared by the Medical Liability Committee of the SMS Physicians Alliance Division. The paper outlines current problems with the medical liability system in Wisconsin and offers recommendations for changing the system that will affect the Wisconsin Health Care Liability Insurance Plan, the Patients Compensation Fund, and the Patients Compensation Panels. These recommendations will form the basis of a medical liability legislative package that the Physicians Alliance will introduce into the next legislative session beginning January 1981. County medical societies are encouraged to include this subject at their meetings during the next few weeks. Copies of the position paper are available from the SMS Physicians Alliance in Madison.

Dues billing and collection

The Council approved a new policy on dues billing and collection whereby the State Medical Society will collect SMS and AMA dues, and state/national voluntary contributions. Each county society can decide whether it wants to collect county dues direct or have them collected by SMS. (In the recent past only two county medical societies have collected their own dues.) If a county society elects to have SMS collect its dues, payments will be made by SMS to the county society under one of the following plans: 1) Check for county dues plus supporting listing would be sent to the county on a regular basis—not more than 30 days after receipt; or 2) Advance payment would be made to the county, based on anticipated dues income.

Appointments

The Council approved the following appointments: To the Commission on Health Planning: Doctors Sigurd E Sivertson, Madison; and Gamber Tegtmeyer, Madison (voting membership status approved) . . . To the Commission on Continuing Medical Education: Doctor Charles W Freeby, Appleton. . . To the Committee on Aging and Extended Care Facilities: Doctor Terrance N Hart, Brookfield.

WMJ Membership Roster

The Council okayed printing of a Membership Roster in the January issue of the *Wisconsin Medical Journal.* This roster will include SMS member address, telephone number, and specialty. Physicians will be receiving a mail request for this information in the coming weeks. The Council urges all members to comply.

4.4% State budget cut

The SMS Council decided not to oppose the State's efforts to trim physicians' portion of the Medicaid budget by 4.4%. SMS agreed to accept a delay in the anticipated 8% increase in reimbursement rates until January 1, 1981. According to individual provider agreements, this increase was supposed to have taken effect on July 1, 1980. Further details of the Council's action were carried in the October issue of *Wisconsin Medical Journal.* ■

SMS President refutes newspaper story

SMS President Russell Lewis, MD, Marshfield, objected to an article October 7 in the *Milwaukee Sentinel* which misquoted him as stating that the State Medical Society would call for a uniform fee schedule for *hospitals.* In his talk before the Wisconsin Association of Nursing Homes, Doctor Lewis said that the State Medical Society would be studying the possibility of equitable fee schedules for physicians. This study is necessary because the Legislature earlier this year directed the Department of Health and Social Services to review physician charges and reimbursement in the T-19 program. The DHSS has prepared such a report and it was delivered to the legislative Joint Committee on Finance October 6.

In addition, the State Medical Society involvement in such a study was prompted by two resolutions of the House of Delegates, offered and accepted by the House in 1975 and 1980. The 1975 Resolution resolved that "the State Medical Society of Wisconsin use all legal means to insure that differences in fees paid to physicians are not the result of geographic discrimination." The 1980 Resolution concluded that "the State Medical Society of Wisconsin supports the establishment of fee structures throughout the state that are equitable and foster physician distribution."

In response to Doctor Lewis's objections, the *Milwaukee Sentinel* ran a correction in the following day's newspaper (October 8).

The Physicians Alliance Commission of the State Medical Society has been reviewing the Department of Health and Social Services report during October and November. ■

CES FOUNDATION

CONTRIBUTIONS—SEPTEMBER 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1980.

Unrestricted

John Allen, MD; Women's Auxiliary to the Medical Society of Milwaukee County; SMS Members-*Voluntary Contributions*

Restricted

Mrs Jack D Edson-*Aesculapian Society (Museum of Medical Progress Endowment Fund)*

LaCrosse County Medical Society-*Museum of Medical Progress Endowment Fund*

Memorials

Gerald C Kempthorne, MD-*James Carlson (General Student Loan Fund)*

Dee Miller-*Robert Carney (General Student Loan Fund)*

Dr-Mrs Robert Schmidt-*Lucille Rogers; J Willard DeBauche (Brown County Loan Fund)*

Roy T Ragatz-*Scott Schweers (Barbara Scott Maroney Memorial Fund)*

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Howard & Barbara Brower-*Edward A Pisczek, MD*

Reese & Mavis Minor-*Robert Carney*

State Medical Society-*Charles H Behnke, MD; Richard A Thayer, MD; Joseph W Lambert, MD; Weston W Jones, MD; Jack B Wilets, MD* ■

State, national conferences on aging slated

The SMS Committee on Aging and Extended Care Facilities informs physicians that the White House Conference on Aging will be held next year from November 30 to December 4. In addition, the State of Wisconsin Conference on Aging will be held in late April or early May 1981. Approximately 1,000 people will be selected from Wisconsin to attend the State Conference; an additional 21 people will be selected from Wisconsin to attend the White House Conference with alternates and other persons to be selected by various congressmen. Potential delegates must complete and submit an application to the local area on aging serving the area in which they live. The application must be submitted before ***December 1, 1980.*** Copies of the application may be obtained from Bill Wendle at SMS offices (phone: 257-6781 or 1-800-362-9080 toll-free). The Committee on Aging and Extended Care Facilities feels that it is important that physicians who are concerned with the care of the aging be represented both in the Wisconsin and National Conferences. Physicians attendance is encouraged. ■

1980-81 Madison teaching seminars announced

Physicians can earn up to 25 hours of Category 1 credit by attending a series of Madison Seminars for Physicians this winter. This year's programs, sponsored jointly by the State Medical Society of Wisconsin's Commission on Continuing Medical Education and the Madison Chapter of the Wisconsin Academy of Family Physicians, will be held on the following dates and locations: Thursday, December 11, 1980, Madison General Hospital, *A Day of Pediatrics;* Wednesday, January 14, 1981, UW Center for Health Sciences, *Adolescent Medicine;* Thursday, February 19, 1981, St Marys Hospital Medical Center, *Diabetes* and *Rheumatology;* Wednesday, March 11, 1981, Methodist Hospital, *Geriatrics: A Young Specialty.*

Each program qualifies for six credits of prescribed AAFP and six hours of Category 1 credit with the exception of the March 11 program which qualifies for seven credits of AAFP and seven hours Category 1 credit. Registration information can be obtained by contacting: Bill Wendle or Arlene Meyer at SMS Madison offices 257-6781 or toll-free 1-800-362-9080. ■

DHSS reports on WMAP go to Legislature

As directed by the Budget Review Bill earlier this year, the Wisconsin Department of Health and Social Services (DHSS) has completed two reports on the Wisconsin Medical Assistance Program (WMAP), and sent them on to the Legislature.

The first report outlines options and recommendations for "case management" within the WMAP, and includes suggestions for expanding the primary provider program and increased use of the "prepaid" approach for T-19 recipients. At the present time, DHSS has existing programs with the Marshfield Greater Community Health Plan in central Wisconsin and the Group Health Cooperative in Dane County in which Medicaid recipients designate those systems as their "primary" provider for services in the WMAP. DHSS feels that savings could be achieved if the approach taken in these two instances was expanded to other areas of the state, particularly in Milwaukee County.

DHSS also recommends that the Legislature review the possibility of establishing a statewide "HMP" approach and indicated their willingness to discuss that approach with the Wisconsin Academy of Family Physicians.

The second report outlines several options available to the Legislature for modifying the methodology used to pay physician claims in the WMAP. At the present time the WMAP pays physicians according to the individual physician's "profile" of charges to Medi*care*. The options range from a statewide fee schedule for physician services regardless of specialty or geographic location, to various composites of specialty, location, and/or range of charges. The five proposals project savings of $15 million per year to $400,000 per year.

The Physicians Alliance Commission of the State Medical Society has done a preliminary review of these two reports and the full reports have been sent to the members of the SMS Council. A brief summary of the reports also were being sent to all county medical society presidents this month for their review and comment. At the present time the Society has *not* taken a position on any of the options. It expects to do so following careful study.

Both reports undoubtedly will receive the attention of the Legislature when it returns in January. Any county medical society interested in discussing these two papers should contact the Physicians Alliance Division of SMS, as both Alliance staff and Commissioners will be available to meet with county societies. ■

SMS evaluates new malpractice insurance company

The Medical Liability Committee of the SMS Physicians Alliance Commission met recently with representatives of Professional Protective Assurance, Inc (PPA). PPA has applied to the Commissioner of Insurance for a Certificate of Authority which would permit PPA to offer medical liability insurance to Wisconsin physicians and has requested State Medical Society support of its proposed insurance program.

Following a thorough evaluation of material provided by PPA and discussion of the goals, objectives, and principles by which PPA will be administered, the Medical Liability Committee has determined that an endorsement of PPA would not be appropriate. The Physicians Alliance has concurred in this decision and will recommend to the Council that the State Medical Society not endorse Professional Protective Assurance, Inc. ■

Seminar for family physicians held Sept 17 in Green Bay

Industrial accidents and high school athletic injuries were discussed at a one-day seminar for family physicians at Bellin Memorial Hospital in Green Bay, September 17. This was the first of three seminars cosponsored by the State Medical Society's Commission on Continuing Medical Education and the Fox Valley Chapter of the Wisconsin Academy of Family Physicians.

Barry V Bast, MD of Manitowoc and Donald M Rowe, MD of Kohler discussed industrial accidents. High school athletic injuries were discussed under the leadership of William G Clancy, MD of Madison and Rolf S Lulloff of Green Bay. ■

Legislative committee to study Patient Compensation Panels

An informal legislative committee has been established to analyze the functioning of the Patient Compensation Panels. The Committee, which consists of two state legislators, three physicians, and four attorneys, has been formed to evaluate the progress of the panels, identify problems with the system, and propose solutions to these problems.

Issues of concern to the Committee include: length of terms to be served by panel members, method of composing panels, responsibilities of individual panel members, appropriate role of informal and formal panels, procedures for conducting panel hearings, amount of per diems paid to panel members, and other matters related to the administration of the panels.

In participating in this evaluation of the panels, the State Medical Society has emphasized that the panel system is a vast improvement over the courts in resolving malpractice disputes. "Fine-tuning" rather than massively restructuring the panel system should be the goal of the Committee.

Members of the Committee include: Rep Thomas Hauke (Chairman, D-West Allis), Rep Joseph Czerwinski (D-Milwaukee), Dr Russell Quirk (Racine), Dr Walter Moritz (Fort Atkinson), Dr William Treacy (Milwaukee), Atty Kurt Kirkhuff (Madison), Atty Steve Caulum (Madison), Atty Ted Warshafsky (Milwaukee), and Atty James Johnson (Rhinelander).

Physicians having proposed topics for Committee consideration are urged to contact the State Medical Society. ■

PAC and GAC deliberate legislative issues

The establishment of legislative policy within the State Medical Society of Wisconsin involves basically four physician bodies with the ultimate authority held by the House of Delegates and, in the interim between meetings of the House, the Council of SMS.

Two physician commissions have the primary day-to-day responsibility for reviewing and acting upon proposals pending in the Legislature. The first of these two bodies—the Physicians Alliance Commission—has responsibility for initiatives in the select areas of professional liability and the medical assistance program. These two issues consume a great deal of the Alliance Commission's work as they are recurrent issues in each legislative session. In addition to these two specific areas, the Physicians Alliance Commission is responsible for proposing policy and implementing the policy decisions of the State Medical Society in general political/legislative organizational efforts; that is, designing the framework for physician involvement in the legislative process.

The Commission on Governmental Affairs is responsible for reviewing, analyzing, and acting upon all other proposals that are considered by the Legislature. These issues range from brain death, to the Medical Practice Act, to examining boards; in effect, all issues other than malpractice and Titles 18 and 19. Because of the complexity of these many issues (nearly 20% of all legislation offered in each session of the Legislature is reviewed by the Commission) the Commission also relies upon the advice of other committees and commissions within SMS as well as special ad hoc committees of the Commission that deal with the specific details of a single bill or issue. The Commission's assessments and recommendations are reviewed by the Council and/or House for policy decisions.

A *Legislative Wrap-up* identifying most of the proposals of concern to the medical profession during the past legislative session appears elsewhere in this issue.

The Physicians Alliance Commission consists of 18 members and is chaired by Kenneth M Viste Jr, MD of Oshkosh. The Commission on Governmental Affairs has nine members and is chaired by Joseph M Lubitz, MD of Oconomowoc. Both commissions have specialty society and/or specialty section representatives with GAC members having the right to vote. Composition of the two commissions follows:

Commission on Governmental Affairs

Joseph M Lubitz, MD, Chairman, 2828 Interlaken Drive North, Oconomowoc 53066 (414/567-0871)

Thomas F Belson, MD, 1111 Delafield Ave, Waukesha 53186 (414/547-1614)

Jack Edson, MD, Box 224, 2712 Stein Blvd, Eau Claire 54701 (715) 834-2751)

Theodore Fox, MD, 214 Fifth Ave, Antigo 54409 (715/623-2351)

Gerald A Gehl, MD, 1215 Doctors Dr, Neenah 54956 (414/725-8285)

Martin L Janssen, MD, Box 10, Friendship 53934 (608/339-3326)

J D Kabler, MD, 1551 University Ave, Madison 53706 (608/262-1885)

Robert F Purtell Jr, MD, 3316 West Wisconsin Ave, Milwaukee 53208 (414/342-4126)

Raymond C Zastrow, MD, 12139 Meadow Ct, Wauwatosa 53222 (414/263-8404)

Section Representatives

Allergy & Immunology: *James Mattson, MD,* Green Bay
Anesthesiology: *Richard Manhart, MD,* Cross Plains
Dermatology:
Emergency Medicine: *Kurt Martyn, MD,* Madison

SMS annuity unit value $3.46

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $3.46 as of August 29, 1980. This compares with $3.42 as of July 31 and $3.17 at June 30. ■

Marijuana hazards focus of Work Week program

"C'mon, pot doesn't hurt me!" How many times have you heard a teenager say this in defense of smoking marijuana? Unfortunately many young adults throughout Wisconsin and the nation believe this to be the case, but new medical research has shown that smoking marijuana daily is damaging both physically and mentally.

Marijuana and the dangers associated with its use was the featured topic at this year's Wisconsin Work Week of Health Program sponsored by the State Medical Society of Wisconsin and its Auxiliary on Tuesday, October 28, at Sentry World Headquarters in Stevens Point and Wednesday, October 29, at the Heritage House in Madison.

Maryland psychiatrist Robert DuPont, MD, current president of both the American Council of Marijuana and the Institute for Behavior and Health, gave a morning presentation entitled "Marijuana Revisited" to more than 400 students at each location. Doctor DuPont is a national authority on this subject and has published many articles on drug use and abuse and is a health commentator on ABC-TV's "Good Morning America." Doctor DuPont was the first director of the National Institute of Drug Abuse.

The afternoon session, entitled "Health Yourself," was directed at helping teenagers face the 80s and focused on self-worth, peer pressure, and communication in the natural family, the one-parent family, and the blended family.

SMS Council Chairman and immediate Past President Darold Treffert, MD, Fond du Lac, presented this portion of the program in Stevens Point and Jack Westman, MD, professor of psychiatry at the University of Wisconsin Medical School in Madison, addressed the subject in Madison.

Work Week of Health is a health education program sponsored annually by the State Medical Society of Wisconsin and its Auxiliary for Wisconsin senior high school students and health educators.

A detailed report of the 1980 Work Week Program will appear in next month's issue of *Wisconsin Medical Journal.* ■

Family Physicians:
Internal Medicine: *Michael Mehr, MD,* Marshfield
Medical Faculties:
Neurology: *Henry A Peters, MD,* Madison
Neurosurgery: *Alan B Levin, MD,* Madison
Obstetrics-Gynecology: *James B Torhorst, MD,* Madison
Ophthalmology: *M Thomas Chemotti, MD,* Cedarburg
Orthopedics: *Marvin W Nelson, MD,* Racine
Otolaryngology: *Larry R Severeid, MD,* LaCrosse
Pathology: *Chesley P Erwin, MD,* Milwaukee
Pediatrics: *Carl Eisenberg, MD,* Milwaukee
Physical Medicine & Rehabilitation: *Richard Harvey, MD,* Madison
Plastic Surgery: *Vaughn Demergian, MD,* Madison
Psychiatry: *Darold A Treffert, MD,* Fond du Lac
Preventive Medicine: *George H Handy, MD,* Madison
Radiology: *Eugene Betlach, MD,* Janesville
Residents: *Mark Liebow, MD,* Madison
Surgery:
Urology: *Raul Waters, MD,* Madison

Invitees

Medical Examining Board: *George Daley, MD,* Milwaukee
Auxiliary: *Mrs Ann Shea,* DePere
Ex officio (Council Chairman): *Darold A Treffert, MD,* Fond du Lac
Ex officio (SMS President): *Russell F Lewis, MD,* Marshfield
Ex officio (SMS President-elect): *Albert J Motzel, MD,* Waukesha

* * *

Physicians Alliance Commission

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Jordon Frank, MD, Vice-chairman, 1969 West Hart Rd, Beloit 53511 (O: 608/362-5642; R: 608/362-4133)
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Richard Stone, MD, 227 E Silver Spring, Milwaukee 53217 (O: 414/961-2020; R: 414/351-4395)
John Thompson, MD, 315 First St, Nekoosa 54457 (O: 715/886-3175)
William Treacy, MD, 10125 W North Ave, Milwaukee 53226 (O: 414/771-9870; R: 414/258-9894)

Ex officio with vote

SMS President: *Russell F Lewis, MD,* Marshfield
Chairman of the Council: *Darold A Treffert, MD,* Fond du Lac
Chairman of the Governmental Affairs Commission: *Joseph M Lubitz, MD,* Oconomowoc

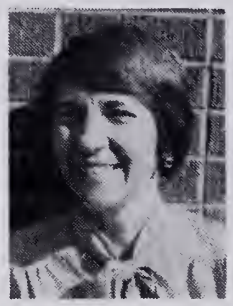
Invitees

SMS President-elect: *Albert J Motzel, MD,* Waukesha
Commission on Public Information: *Richard Henry, MD,* Reedsburg
Auxiliary Legislative Chairman: *Mrs Ann Shea,* DePere
Auxiliary Representative to PAC: *Mrs Audrey Peterson,* Madison

Specialty *Representatives to PAC*

Robert Kriz, MD, Madison (Allergy Society and Section)
Richard Manhart, MD, Cross Plains (Anesthesiology Section)
Robert McDonald, MD, Madison (Dermatology Section)
Richard Chambers, MD, Hartland (Family Physicians Section)
Mark Ciccantelli, MD, Wauwatosa (Medical Faculties Section)
Michael McQuillen, MD, Milwaukee (Neurology Section)
Allan Levin, MD, Madison (Neurosurgical Society and Section)
William O'Leary, MD, LaCrosse (Obstetrics-Gynecology Section)
Ed Bercovici, MD, Milwaukee (Ophthalmology Section)
Joseph Selliken, MD, Madison (Resident Physicians Section)
John Guy, MD, Waukesha (Pediatrics Section)
William LaJoie, MD, Waukesha (Physical Medicine & Rehabilitation Section)
Sidney K Wynn, MD, Milwaukee (Plastic Surgery Section)
Richard Biek, MD, Waupaca (Public Health & Preventive Medicine Section)
P Richard Sholl, MD, Janesville (Surgery Section)
John Clemons, MD, LaCrosse (Otolaryngological Society)
Dean Connors, MD, Madison (Pathology Society)
Robert Goerke, MD, Milwaukee (Psychiatrists Society)
Randle Pollard, MD, Milwaukee (Urology Section)
Timothy Flaherty, MD, Neenah (Radiology Section)
Donald Babbitt, MD, Milwaukee (Radiological Society)
Derek Cripps, MD, Madison (Dermatological Society)
Phiroze Hansotia, MD, Marshfield (Neurological Society)
Richard Wixson, MD, Madison (Orthopedics Society)
Kenneth A Stormo, MD, Fond du Lac (Pathology Section)
John Kirkpatrick, MD, Madison (Radiation Oncologists Society)
Stephen Cushman, MD, Racine, or *Mohammed Rafiullah, MD,* Racine (Neurosurgical Society)
Timothy Helz, MD, Hartland (Emergency Medicine Section)
Russell P Sinaiko, MD, Madison (Surgical Society) ■

Physicians! These people are at your service: SMS Physicians Alliance field consultants



LOIS RILEY

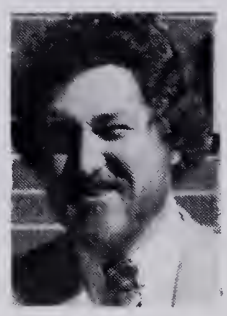
District 1
414/271-4328*
414/964-6524 (Home)

Milwaukee

KEN OPIN

District 2
608/257-6781*
608/255-2226 (Home)

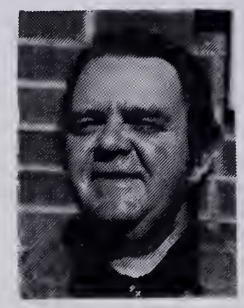
Dane
Grant
Green
Iowa
Jefferson
Lafayette
Richland
Rock



PAUL JACOBSON

District 4
715/835-1753*
715/835-1753 (Home)

Ashland
Barron
Bayfield
Buffalo
Burnett
Chippewa
Clark
(Western Half)
Crawford
Douglas
Dunn
Eau Claire
Iron
Jackson
La Crosse
Monroe
Pepin
Pierce
Polk
Price
(Northern Half)
Sawyer
St. Croix
Trempealeau
Vernon
Washburn



MARV STROMER

District 5

715/845-8259*
608/868-2334 (Home)

Adams
Clark
(Eastern Half)
Columbia
Florence
Forest
Green Lake
Jefferson
(Northwest Corner)
Juneau
Langlade
Lincoln
Marathon
Marinette
(Northern Half)
Marquette
Oconto
(Northwest)
Oneida
Price
(Southern Half)
Portage
Rusk
Shawano
Taylor
Vilas
Waushara
Wood

TIM LYNCH

District 6
414/271-4328*
414/475-5430 (Home)

Kenosha
Ozaukee
Racine
Walworth
Washington
Waukesha

VACANT

District 3
Brown
Calumet
Dodge
Door
Fond du Lac
Kewaunee
Manitowoc
Marinette
(Southern Half)
Oconto
(Southeast)
Outagamie
Sheboygan
Waupaca
Winnebago

*Field consultant answering service

The goal of the State Medical Society's Physicians Alliance is to motivate, activate and involve physicians in returning to their proper place in the mainstream of health-care policy formulation and in personal involvement of health-related activities of their communities. The Alliance field consultants are there to help physicians at the local and county levels achieve this goal.

LEGISLATIVE WRAP-UP

inning in January 1981 the Wisconsin Legislature will convene another session which is sure to see several new es as well as a host of new ideas. As in past sessions, the State Medical Society's Commission on Governmental airs and Physicians Alliance Commission will review health-related issues coming before the Legislature (see ated article elsewhere in this issue). The following "Legislative Wrap-up" identifies most of the proposals of cern to the medical profession during the past legislative session. Although some of these proposals passed will not have to be dealt with again, many will most likely be reintroduced in the next session for considera- n. Physicians are encouraged to express their views to these commissions on any legislative issues during the rse of the next session. This can be accomplished via the Physicians Alliance field consultants (see listing ewhere in this issue) or by contacting the Physicians Alliance Division at SMS headquarters in Madison: phone -6781 (regular) or 1-800-362-9080 (toll-free). As always, physicians are especially encouraged to contact ir legislators to present their views on legislation.

REGULATION AND LICENSING

Bill/Sponsors	Synopsis	SMS Position	Final Status
letic Trainers 9/Sen. Cullen (D-Janesville)	Regulates and licenses athletic trainers through the Medical Examining Board.	Oppose	Died in Joint Finance Committee.
upational Therapists 78/Human Services Com- tee	Regulates and licenses occupational therapists through the Medical Examining Board.	Support	Passed Senate. Concurred in as amended by Assembly. Failed to receive final Senate action.
45/Health & Social Ser- es Committee	Same as SB178.	Support	Died in Health & Social Services Committee.
minating Regulatory Agen- s 59/Sen. Cullen (D-Janesville)	Establishes a schedule for "sunsetting" state regulatory agencies, including the Medical Examining Board, unless recreated by the legislature.	Oppose	Died in Joint Finance Comm.
se-Midwives 6/Rep. Hauke (D-West Allis)	Allows for the certification of nurse-midwives by the Board of Nursing. Nurse-midwives are to practice under the general supervision of, and within the scope of a formal written agreement with, a physician trained in obstetrics.	Support	Law. (Chapter 317, Laws of 1979.)
73/Sen. Offner (D-La Crosse)	Generally the same as AB66.	Support	Passed Senate. Died in H&SS Committee.
nining Board Appeals 10/Joint Administrative es Committee	Requires the Department of Regulation and Licensing to pay attorney fees and costs incurred by persons receiving successful appeals of examining board decisions.	Monitor	Passed Senate. Died in H&SS Committee.
ay Operators 24/Rep. D. Travis (D-Madison)	Requires the Medical, Dentistry, and Chiropractic Examining Boards to establish minimum standards for the certification of persons operating X-Ray machines.	Support	Vetoed.
Temporary License 77/Remedial Legislation nittee	Allows for the temporary licensing of physicians assistants during the interim between graduation and receipt of national examination results.	Support	Law. (Chapter 337, Laws of 1979.)

REGULATION AND LICENSING

Bill/Sponsors	Synopsis	SMS Position	Final Stat
Examining Board Membership AB1070/Rep. Munts (D-Madison)	Revises membership of Medical Examining Board whereby public membership is increased to three and professional members are reduced to four. Present law requires seven physicians, one osteopath and one public member to serve on the Board.	Oppose	Tabled in Assembly.
AB1100/Rep. Norquist (D-Milwaukee)	Revises membership of Medical Examining Board establishing a public majority of four along with two physicians and one osteopath.	Oppose	Died in Cor merce & Cor er Affairs
AB1180/Joint Finance Committee (Budget Review Bill)	Prohibits any officer, director or employee of a private professional organization from being appointed to that profession's examining board.	Monitor	Law. (Chap 221, Laws 1979.)

MEDICAL LIABILITY

Bill/Sponsors	Synopsis	SMS Position	Final Stat
Podiatrist Coverage SB75/Human Services Committee	Includes podiatrists as eligible participants in the Patient Compensation Fund and Patient Compensation Panels for medical malpractice proceedings.	Support	Law. (Chap 185, Laws 1979.)
Patient Compensation Fund SB565/Joint Administrative Rules Committee	Repeals statutory provision which limits Patient Compensation Fund fee to 10% of premium charged under the Health Care Liability Insurance Plan. The Insurance Commissioner, instead, is authorized to set fee assessments by administrative rule. Provisions allowing the Insurance Commission to levy deficit assessments are also repealed. Reserves for unreported claims will take into consideration the investment income to be earned on the Fund during the lag time between the occurence of an injury and the actual filing of the claim.	Support (SMS Bill)	Law. (Chap 194, Laws 1979.)
Court Sites AB185/Rep. Hauke (D-West Allis)	Requires negligence actions against insurance companies to be tried in either the county where the plaintiff resides or where the insurance company has its home office.	Oppose	Passed Ass Died in Jud ciary & Cor mer Affairs Committee.
Discovery Rule AB326/Rep. Rutkowski (D-Hales Corners)	Establishes a statute of limitations for injury discovery specific to medical malpractice actions. Malpractice actions may now be brought within three years of injury occurence (present law) or one year from date of injury discovery, not to exceed five years. For foreign objects left in the body, actions may be brought within one year after discovery with no limitations.	Successful in reducing discovery from 6 to 5 years. Attempted to reduce to 4.	Law. (Chap 323, Laws 1979.)
AB327/Rep. Becker (D-Milwaukee)	Provides that medical malpractice proceedings may be brought within 3 years after a person discovers an injury regardless of when injury occurred.	Oppose	Died in Jud ciary Commi
Expert Medical Witness AB637/Rep. McClain (D-Wausau)	Specifies that expert medical witnesses in medical malpractice proceedings must be licensed and practicing in Wisconsin or a contiguous state. It also requires the witness' experience, training, and knowledge qualify him or her to testify on the subject at issue.	Support (SMS Bill)	Died in Jud ciary Commi
Binding Arbitration AB638/Rep. McClain (D-Wausau)	Provides a mechanism for the use of voluntary binding arbitration between health care providers and patients in settling medical malpractice claims.	Support (SMS Bill)	Died in Jud ciary Commi
Attorney Fees AB654/Rep. Ulichny (D-Milwaukee)	Provides that determination of an attorney's contingency fee from a medical malpractice action may be based on the total award for future medical expenses. Present law allows contingency fee to be based on the first $25,000 only.	Oppose	Tabled in Assembly.

MEDICAL LIABILITY

Bill/Sponsors	Synopsis	SMS Position	Final Status
el Findings 55/Rep. Ferrall (D-Racine)	Provides that findings of Formal Patient Compensation Panels in medical malpractice proceedings are inadmissable in circuit court actions.	Oppose	Died in Judiciary Committee.
21/Rep. Ferrall (D-Racine)	Consolidates the Formal and Informal Patient Compensation Panels into one type of panel and renders findings inadmissable in circuit court. Removes all statutory restrictions on which attorneys may base their fees.	Oppose	Died in Financial Institutions Committee.
urer Reports 180/Joint Finance Comtee (Budget Review Bill)	Continues the requirement that health professional liability insurers submit annual reports to the Insurance Commissioner detailing the number of insureds in each rating class, amount of premiums paid, and number and amount of claims in each rating class until 30 days after passage of the 1981-83 biennial budget.	Support	Law. (Chapter 221, Laws of 1979.)

HEALTH INSURANCE

Bill/Sponsors	Synopsis	SMS Position	Final Status
chologists 9/Human Services Comm.	Requires all health insurance policies to provide coverage for services of clinical psychologists if the policy extends coverage for similar services when provided by a physician.	Oppose	Died in Insurance & Utilities Committee.
7/Rep. Ferrall (D-Racine)	Same as SB29.	Oppose	Indefinitely Postponed in Assembly.
28/Rep. Clarenbach (D-Madison)	Same as SB29 and AB67, except coverage is extended to any licensed psychologist.	Oppose	Died in H&SS Committee.
ropractors 0/Insurance & Utilities mittee	Requires all health insurance policies to provide coverage for services of chiropractors.	Oppose	Indefinitely Postponed in Senate.
03/Financial Institutns Committee	Same as SB30.	Oppose	Died in Joint Finance Comm.
te Health Insurance 4/Sen. Berger (D-Milwaukee)	Creates a State Accident and Sickness Fund managed by the Insurance Commissioner to provide health insurance for state residents opting for Fund coverage and paying a premium.	Monitor	Died in Insurance & Utilities Committee.
e Payment Charges 44/Legislative Council	Repeals an existing law which allows 12% annual interest charges to be assessed against insurance companies for failure to pay claims within 30 days after notification.	Oppose	Vetoed.
urance for Uninsurables 00/Sen. Radosevich (D-North Hudson)	Establishes an insurance risk sharing program which provides health insurance coverage for persons unable to obtain adequate coverage on the voluntary market due to health underwriting reasons.	Support	Law. (Chapter 313, Laws of 1979.)
39/Rep. Czerwinski (D-Milwaukee)	Same as SB400.	Support	Tabled in Assembly.
20/Sen. McCallum (R-Fond du Lac)	Same as SB400.	Support	Died in Joint Finance Comm.
02/Legislative Council	Same as SB400.	Support	Died in Joint Finance Comm.
amedics 87/Sen. Frank (D-Milwaukee)	Requires all health insurance policies issued or renewed to contain coverage for services of paramedics.	Oppose	Died in Insurance & Utilities Committee.

HEALTH INSURANCE

Bill/Sponsors	Synopsis	SMS Position	Final Status
Hospices SB534/Sen. Cullen (D-Janesville)	Requires all insurance policies to provide coverage for hospice care.	Oppose	Died in Join Finance Comm
Insurance Conversion AB443/Rep. Czerwinski (D-Milwaukee)	Provides an option for insured or dependents to continue group health insurance coverage when coverage would normally terminate due to employment termination, divorce, or death of the insured.	Support	Law. (Chapte 285, Laws of 1979.)
SB560/Sen. Moody (D-Milwaukee)	Same as AB443.	Support	Passed Senat Died in Fina cial Institu tions Comm.
Claim Forms AB243/Rep. Behnke (D-Milwaukee)	Prohibit charging a fee for completing a health insurance claim form on behalf of an insured. *This position should not be construed to mean SMS favors charging fees for completing insurance claim forms; it does not. However, there are occasions when patients have several forms to be completed where the option to charge a fee should remain open.	Oppose*	Vetoed.
Minimum Benefits AB437/Rep. Czerwinski (D-Milwaukee)	Requires the Insurance Commissioner to establish, by administrative rule, minimum benefit levels for specified services covered in health insurance policies.	Support	Vetoed.
Catastrophic Insurance AB438/Rep. Czerwinski (D-Milwaukee)	Establishes a Catastrophic Illness Insurance Plan whereby persons incurring heavy medical expenses may obtain state aid. Aid is to based on income and a threshold formula based on how well an eligible person is insured for the illness.	Support	Died in Join Finance Comm
Non- Smokers' Insurance AB590/Rep. Duren (D-Cazenovia)	Requires health and life insurers to establish rate classifications which distinguish in favor of non-smokers.	Monitor	Died in Fina cial Institu tions Comm.
Emergency Room Deductibles AB780/Rep. Leopold (D-Milwaukee)	Requires a $6 deductible for all emergency room visits covered under health insurance policies. Physicians fees are excluded if billed separately from emergency room service.	Conditional Support	Died in Rule Committee.
Office Visit Coverage AB820/Rep. Czerwinski (D-Milwaukee)	Requires all health insurance policies which provide coverage for emergency room services to also provide coverage for at least 2 policyholder visits to a physician's office per year.	Monitor	Died in Join Finance Comm
Coherent Policies AB1207/Rep. Hauke (D-West Allis)	Requires insurance policies to be written in coherent commonly understood language. The Insurance Commissioner is to implement this policy through administrative rule.	Monitor	Law. (Chapte 218, Laws of 1979.)

MEDICAL AND PUBLIC HEALTH ISSUES

Bill/Sponsors	Synopsis	SMS Position	Final Status
Plan of Care SB79/Joint Finance Committee (Biennial Budget Bill)	Prohibits nursing homes from admitting patient until a physician has completed a plan of care for the patient.	Monitor	Law. (Chapte 34, Laws of 1979.)
Child Nutrition SB154/Education & Revenue Committee	Establishes a Child Nutrition Program by supplementing the Federal School Breakfast and Lunch Program with State funds.	Monitor	Died in Join Finance Comm
Brain Death SB181/Legislative Council	Provides for a statutory recognition of brain death based on irreversible cessation of all functioning of the brain.	Support	Indefinitely Postponed in Senate.
AB1132/Rep. Czerwinski (D-Milwaukee)	Same as SB181.	Support	Passed Assem y Senate Nonco curred.

MEDICAL AND PUBLIC HEALTH ISSUES

Bill/Sponsors	Synopsis	SMS Position	Final Status
31133/Rep. Czerwinski (D-Milwaukee)	Removes any liability from health care providers for withholding medical treatment from brain dead patients.	Support	Died in H&SS Committee.
31141/Rep. Medinger (D-La Crosse)	Allows health care institutions to discontinue or withhold artificial life support systems from brain dead patients after death is certified in writing by two physicians, and permission is granted by the family.	Oppose	Died in Human Services Comm.
nshot Wounds 3282/Sen. Cullen (D-Janesville)	Requires health care providers to immediately report to law enforcement authorities all gunshot wounds, and any other injuries sustained in the commission of a crime.	Support	Passed Senate. Tabled in Assembly.
bies Control 3751/Rep. Otte (D-Sheboygan)	Establishes a rabies control program through strengthening of the dog licensing laws.	Support	Law. (Chapter 289, Laws of 1979.)
3283/Sen. Berger (D-Milwaukee)	Same as AB751.	Support	Died in Human Services Comm.
ortion 3315/Sen. Swan (D-Milwaukee)	Requires health care professionals to exercise all professional skill to preserve the life of an aborted viable fetus. Failure to exercise such care constitutes manslaughter or 2nd degree murder.	Monitor	Died in Human Services Comm.
159/Rep. Behnke (D-Milwaukee)	Requires hospitals and clinics performing abortions to dispose of fetus by incineration or burial, unless the woman requests the fetus be released to her for disposal.	Monitor	Passed Assembly. Died in Human Services Comm.
475/Rep. Medinger (D-La Crosse)	Makes various changes relating to regulation of abortions and emphasizes the state's opposition to abortion.	Monitor	Died in H&SS Committee.
564/Rep. Klicka R-Wauwautosa)	Requires physicians performing abortions to file abortion certificates with local health officer detailing the method of abortion, weight of the fetus and any other information requested by the Department of Health & Social Services.	Monitor	Died in H&SS Committee.
ntal Health 913/Health & Social rvices Committee	Creates an additional standard for involuntary committment under the Mental Health Act.	Support	Law. (Chapter 336, Laws of 1979.)
417/Judiciary & Consumer fairs Committee	Same as AB913.	Support	Died in Judiciary & Consumer Affairs.
848/Rep. Shabaz (R-New Berlin)	Similar to AB913 & SB417.	Support	Died in H&SS Committee.
230/Rep. Clarenbach (D-Madison)	Creates a state funded treatment program for persons suffering from neurological disorders (epilepsy, cerebral palsy, Parkinson's Disease, muscular dystrophy, multiple sclerosis, autism or other neurological disorders not demonstrably related to mental retardation). Requires release of these patients from involuntary commitment or protective placement, and requires expunging reference to commitment or placement from patient's treatment record.	Monitor	Died in H&SS Committee
994/Legislative Council	Revises various laws affecting the Mental Health Act.	Oppose	Tabled in Assembly.

MEDICAL AND PUBLIC HEALTH ISSUES

Bill/Sponsors	Synopsis	SMS Position	Final Statu
AB1160/Rep. Wood (D-Janesville)	Requires inpatient mental health facilities to notify the family of the release of voluntarily committed patients, unless the patient objects.	Monitor	Died in H&S Committee.
Anaphylactic Shock AB246/Rep. Loftus (D-Sun Prairie)	Allows EMT's to receive training and administer injections, upon physicians orders, to victims of anaphylactic shock.	Support	Law. (Chapt 321, Laws o 1979.)
Motorcycle Helmets AB329/Rep. Broydrick (D-Milwaukee)	Reinstates the mandatory motorcycle helmet law.	Support	Died in Tra portation C
Public Health Aids AB343/Rep. Czerwinski (D-Milwaukee)	Provides state aid to city and county public health departments for the provision of certain health services.	Support	Died in Joi Finance Com
Choking Victims AB375/Rep. Menos (D-Glendale)	Requires restaurants to post signs in areas frequented by employees explaining how to assist choking victims by the Heimlich Maneuver Method.	Support	Died in H&S Committee.
Family Planning AB379/Rep. Hephner (D-Chilton)	Requires publicly funded family planning agencies to notify parents if their minor child seeks family planning services.	Oppose	Died in H&S Committee.
AB441/Rep. Hopkins (R-Chippewa Falls)	Same as AB379.	Oppose	Died in H&S Committee.
AB701/Rep. Hauke (D-West Allis)	Same as AB379.	Oppose	Died in H&S Committee.
Health Planning Aids AB529/Rep. Czerwinski (D-Milwaukee)	Authorizes state funding for sub-state health planning agencies for purposes of administering functions required by federal law.	Support	Died in Joi Finance Com
Optometric Referral AB560/Remedial Legislation Committee	Subjects optometrists to license revocation or suspension for non-referral of a pathological condition.	Support	Law. (Chapt 162, Laws o 1979.)
CPR Instruction AB620/Rep. Duren (D-Cazenovia)	Requires high schools to provide instruction in CPR.	Support	Died in Edu tion Comm.
AB677/Rep. Czerwinski (D-Milwaukee)	Requires Junior and Senior High Schools to provide instruction in first aid and basic life support.	Support	Died in Joi Finance Com
Immunization AB767/Rep. Czerwinski (D-Milwaukee)	Requires all school children to be immunized against all preventable diseases as a condition of admittance. Exemptions are provided for religious, medical and personal conviction reasons.	Support	Law. (Chapt 334, Laws o 1979.)
Natural Death Act AB779/Rep. Flintrop (D-Oshkosh)	Allows adult patients to file a directive in their medical records requesting that extraordinary means of life support be withheld should they ever face a terminal condition.	Support Principle	Died in H&S Committee.
s.51.42 Treatment Directors AB863/Rep. Jackamonis (D-Waukesha)	Allows psychologists to serve as clinical treatment directors for services provided under s. 51.42 Boards. (Presently, only psychiatrists.)	Oppose	Died in H&S Committee.
Blood Pressure Programs AB867/Rep. Leopold (D-Milwaukee)	Provides supplemental state funding for high blood pressure programs in the state.	Support	Died in Joi Finance Com
Patient Rights AB872/Rep. Clarenbach (D-Madison)	Establishes criteria relating to the rights and responsibilities of patients.	Oppose	Died in H&S Committee.
Emergency Medical Information AB942/Rep. Ward (D-Milwaukee)	Permits emergency medical information on the backside of drivers' license.	Support	Died in Hig Committee.

MEDICAL AND PUBLIC HEALTH ISSUES

Bill/Sponsors	Synopsis	SMS Position	Final Status
tient Records 1180/Joint Finance mm.(Budget Review Bill)	Relates to confidentiality of patients records and prohibits release of medical records without informed consent, with certain exceptions. Health care providers and institutions are required to provide patients with a statement detailing the patients rights to inspect their health care records.	Support	Law. (Chapter 221, Laws of 1979.)
-Ray Equipment Transfers 1180/Joint Finance Committee (Budget Review Bill)	Requires new owners in radiation equipment transfers to notify the Department of Health and Social Services within 15 days of the change in control.	Monitor	Law. (Chapter 221, Laws of 1979.)
eath Certificates 1180/Joint Finance Committee (Budget Review Bill)	Requires physicians in charge of patients' care for the illness or condition resulting in death to complete and sign the death certificate in black ink. In the absence of, or with the approval of, the physician in charge of the patient's care, another physician who has access to the medical history of the case may sign the death certificate. Coroners or medical examiners may sign, or may employ a physician to complete and sign death certificates only after death inquests, where no physician was in charge of the case, or where the physician in charge refuses to complete and sign. If causes of death are unknown, undetermined or if determination is pending, this fact shall be shown on the death certificate. As soon as findings are available to the person signing the certificate, an amendment to the death certificate shall be forwarded to the state registrar.	Monitor	Law. (Chapter 221, Laws of 1979.)
fant Blindness 1180/Joint Finance Committee (Budget Review Bill)	Removes the requirement that only a one percent solution of silver nitrate may be used for the prevention of ophthalmia neonatorum or infant blindness. Authorizes the Department of Health and Social Services to approve appropriate prophylactic agents. (The Department is currently proposing the use of tetracycline and erythromycin as well as silver nitrate.)	Support	Law. (Chapter 221, Laws of 1979.)
bella Immunity 1219/Rep. Czerwinski (D-Milwaukee)	Requires women under the age of 55 to have a test for rubella immunity as a condition of obtaining a marriage license.	Oppose	Died in H&SS Committee.
nereal Disease 1257/Rep. Clarenbach (D-Madison)	Creates a state program for treating venereal disease and informing citizens on venereal disease. The Department of Health and Social Services is required to reimburse physicians for the cost of treating venereal disease. It also requires persons applying for marriage licenses to have a culture test for gonorrhea.	Monitor	Died in H&SS Committee.
dney Dialysis 1274/Rep. Czerwinski (D-Milwaukee)	Requires kidney disease patients who receive outpatient dialysis at hospitals or kidney disease treatment centers to pay $10 for each treatment. Patients using home dialysis are not required to pay for treatment.	Monitor	Died in Rules Committee.
dical Examiners nate Joint Resolution 35/ n. Lasee (R-DePere)	Directs the Legislative Council to study existing state system of death investigation and to consider the advisability of creating a state medical examiner system.	Support Principle	Passed Senate. Died in Government Operations Committee.
nate Joint Resolution 36/ n. Lasee (R-DePere)	Abolishes the office of Coroner in favor of a medical examiner system.	Support Principle	Died in Government & Veterans Affairs Comm.

DRUGS AND ALCOHOL

Bill/Sponsors	Synopsis	SMS Position	Final Status
Drinking Age SB19/Sen. Chilsen (R-Wausau)	Raises minimum drinking age to 19.	Support "21"	Passed Senate Died in State Affairs Comm.
AB79/Rep. Klicka (R-Wauwatosa)	Raises minimum drinking age to 19.	Support "21"	Died in State Affairs Comm.
AB98/Rep. Vanderperren (D-Green Bay)	Raises minimum drinking age to 19.	Support "21"	Died in State Affairs Comm.
AB197/Rep. Wood (D-Janesville)	Raises minimum drinking age to 19.	Support "21"	Died in State Affairs Comm.
AB260/Rep. Goodrich (R-Berlin)	Raises minimum drinking age to 19.	Support "21"	Died in State Affairs Comm.
AB236/Rep. Hephner D-Chilton)	Raises minimum drinking age to 19. High School graduates to have a minimum drinking age of 18.	Support "21"	Died in State Affairs Comm.
AB399/Rep. Metz (D-Green Bay)	Raises minimum drinking age to 19 by raising age of majority to 19, voting privileges excepted.	Monitor	Died in State Affairs Comm.
AB250/Rep. Duren (D-Cazenovia)	Raises minimum drinking age to 21.	Support	Died in State Affairs Comm
SB38/Sen. Radosevich (D-North Hudson)	Raises age for sale of beer and liquor for consumption and possession away from a licensed establishment to 21. Maintains age 18 for consumption in licensed establishments.	Support "21"	Died in Agin Business & F nancial Inst tutions & Tr sportation C
SB232/Sen. Murphy (R-Waukesha)	Same as SB38, except raises to age 19 for off premise consumption and possession.	Support "21"	Died in Agin Bus. & Finan- cial Insts. Transp. Comm
AB62/Rep. Medinger (D-La Crosse)	Same as SB232.	Support "21"	Died in Stat Affairs Comm
AJR118/Rep. Duren (D-Cazenovia)	Calls for an advisory referendum at the November, 1980 election on the question of enacting legislation to increase the minimum drinking age from 18 to 21.	Monitor	Died in Stat Affairs Comm
Drug Abusers SB162/Human Services Committee	Establishes procedures for diverting certain drug abusers charged with crimes from the criminal justice system into the drug abuse treatment system.	Support	Died in Judi ciary & Con- sumer Affair Committee.
SB164/Human Services Committee	Changes the Mental Health Act to extend the current provisions concerning commitment and treatment of alcohol abusers to apply to drug abusers. Present law generally subjects drug abusers to the same laws which govern commitment and treatment of the mentally ill. The bill also transfers liability ($500 forfeiture) for refusal to admit a drug or alcohol abuser in need of treatment from the hospital to the admitting physician. *Oppose pending removal of physician liability.	Oppose*	Died in Join Finance Comm
SB165/Human Services Committee	Amends an existing law which requires group health insurance policies to cover outpatient services for mental and nervous disorders, alcoholism and drug abuse provided under s.51.42 Board structure. This bill extends that requirement to individual policies and also provides coverage for providers outside the s.51.42 Board structure.	Support	Died in Huma Services Com
AB778/Rep. Czerwinski (D-Milwaukee)	Similar to SB165.	Support	Died in H&SS Committee.

DRUGS AND ALCOHOL

Bill/Sponsors	Synopsis	SMS Position	Final Status
rug Paraphernalia 3198/Sen. Lasee (R-DePere)	Bans the manufacture and sale of drug paraphernalia used for smoking or ingesting marijuana, hashish or cocaine.	Support Principle	Died in Judiciary & Consumer Affairs Committee.
3513/Rep. Klicka (R-Wauwatosa)	Same as SB198.	Support Principle	Died in Judiciary Comm.
·ug Prescriptions 3210/Sen. Krueger (R-Merrill)	Allows prescriptions for controlled substances from out-of-state practitioners to be honored by Wisconsin pharmacies.	Oppose	Died in Judiciary & Consumer Affairs Comm.
·ug Burglaries 347/Rep. Hephner (D-Chilton)	Increases maximum penalty for burglary with intent to steal a controlled substance from 10 years to 20 years imprisonment.	Monitor	Died in Criminal Justice & Public Safety Committee.
·dical Marijuana 107/Rep. Lingren (D-Menomonee Falls)	Creates a Controlled Substances Therapeutic Research Program that allows cancer chemotherapy and radiotherapy patients and glaucoma patients to use marijuana and THC. Eligible patients are to be certified by a Patient Qualification and Review Board composed of physicians. The Dept. of Health and Social Services would contract with the federal government for receipt of the marijuana.	Oppose*	Died in H&SS Committee.
279/Rep. Clarenbach (D-Madison)	The same as AB107 except that a pharmacist serves on the board as well as physicians, and locally confiscated or state grown marijuana may be used in the program in addition to federally grown marijuana. *The Medical Society does not oppose the use of marijuana for medical purposes; its primary objection to the above bills was the creation of another board to operate the program when an existing board, the Controlled Substances Board, may approve the use of marijuana and THC for research purposes.	Oppose*	Died in Rules Committee.
·eatment of Minors 742/Rep. Barry (D-Mount Horeb)	Revises several drug and alcohol laws involving minors. Allows physicians and health care facilities to render preventive, diagnostic, evaluation or treatment services for drug and alcohol abuse to minors, 12 years or older, without parental consent. Parental consent continues to be required where treatment involves surgery, administration of drugs, except to detoxify, or admission to an inpatient treatment facility, excluding the first 72 hours of detoxification.	Monitor	Law. (Chapter 331, Laws of 1979.)
Ftal Alcohol Syndrome 305/Rep. Metz (D-Green Bay)	Requires Fetal Alcohol Syndrome warning labels and signs to be printed on alcoholic beverage containers and posted in licensed retail establishments.	Monitor	Died in Commerce & Consumer Affairs Committee.
145/Rep. Metz (D-Green Bay)	Requires the Department of Health and Social Services to purchase radio broadcasts and TV announcements on Fetal Alcohol Syndrome. Funding to be derived from an increase in the beer and liquor tax.	Monitor	Died in Commerce & Consumer Affairs Committee.
C:izens Council A.180/Joint Finance Com- m:tee (Budget Review Bill)	Abolishes Citizens Advisory Committee on Alcoholism and the Council on Drug Abuse and establishes a 20 to 30 member Citizens Council on Alcohol and other Drug Abuse. Drug and Alcohol activities of the Health Policy Council is transferred to this Council. The Council is to advise the Governor, legislature, and government agencies on plans, budgets and operations of drug and alcohol abuse programs.	Monitor	Law. (Chapter 221, Laws of 1979.)

ENVIRONMENTAL HEALTH

Bill/Sponsors	Synopsis	SMS Position	Final Statu
Smoking SB80/Sen. Risser (D-Madison)	Regulates smoking in certain buildings and conveyances to which the public has access.	Support	Indefinitel Postponed i Senate.
AB80/Rep. Munts (D-Madison)	Same as SB80.	Support	Died in Joi Finance Com
Rat Control AB130/Rep. Coggs (D-Milwaukee)	Authorizes the Department of Health and Social Services to provide financial assistance to local rat control programs.	Support Principle	Died in H&S Committee.
Nuclear Power AB180/Rep. Clarenbach (D-Madison)	Prohibits public utilities from constructing, installing or operating nuclear power plants until the Public Service Commission determines there are adequate methods for disposal of nuclear wastes.	Monitor	Died in Ene Committee.
Radiation Protection Council AB209/Legislative Council	Revises the membership and broadens the scope of the Radiation Protection Council.	Support	Law. (Chapt 320, Laws o 1979.)
Radioactive Waste Transport AB210/Legislative Council	Requires transporters of radioactive wastes to be licensed by the Department of Natural Resources and to notify the Department of Transportation on intent to transport wastes through the state.	Support Principle	Tabled in Assembly.
Decommissioning Power Plants AB211/Legislative Council	Requires public utilities proposing to construct nuclear power plants to submit advance plans for decommissioning to the Public Service Commission.	Support Principle	Died in Env mental Reso Committee.
Waste Disposal Sites AB212/Legislative Council	Directs the Attorney General to intervene into any Nuclear Regulatory Commission proceeding concerning construction of radioactive waste disposal sites in Wisconsin.	Support Principle	Died in Rul Committee.
Lake Chemicals AB231/Rep. Clarenbach (D-Madison)	Requires a Department of Natural Resources permit before chemical treatment may be applied to any lake. Any municipality bordering the lake may disapprove of the chemical use, thereby denying the permit.	Monitor	Died in Env mental Reso Committee.
2,4,5-T Ban AB245 & AB937/Rep. Loftus (D-Sun Prairie)	Bans the sale, use, and manufacture of the dioxin containing herbicides 2,4,5-T and Silvex in Wisconsin.	Support	Died in Agr culture Com
2,4-D Ban AB303/Rep. Clarenbach (D-Madison)	Bans the sale and use of the chemical herbicide 2,4-D in Wisconsin.	Monitor	Died in Env mental Reso Committee.
Mosquito Control AB312/Rep. Medinger (D-La Crosse)	Allows multiple counties to jointly establish tax supported Mosquito Control Districts.	Support	Law. (Chapt 122, Laws o 1979.)
Auto Inspection AB500/Environmental Resources Committee	Establishes an auto air emission inspection program in 7 southeastern counties as required by federal law.	Monitor	Law. (Chapt 274, Laws o 1979.)
Agent Orange AB1180/Joint Finance Comm. (Budget Review Bill)	Requires the Division of Health to submit a plan to the legislature detailing a method for assisting Vietnam Veterans exposed to Agent Orange.	Monitor	Law. (Chapt 221, Laws o 1979.)
Radiation Monitoring AB1180/Joint Finance Comm. (Budget Review Bill)	Appropriates funding to conduct radiation monitoring programs in areas around nuclear power plants and uranium mining sites.	Monitor	Law. (Chapt 221, Laws o 1979.)
Lead Poisoning AB1180/Joint Finance Comm. (Budget Review Bill)	Establishes a lead poisoning prevention program in the Department of Health and Social Services. Physicians are required to report cases of lead poisoning to local health officer.	Support Principle	Law. (Chapt 221, Laws o 1979.)

TITLE XIX - MEDICAID

Bill/Sponsors	Synopsis	SMS Position	Final Status
ursing Home Admittance B79/Joint Finance Committee Biennial Budget Bill)	Requires nursing homes to admit patients 7 days a week as a condition of reimbursement under medical assistance.	Monitor	Law. (Chapter 34, Laws of 1979.)
sychotherapy Rules B321/Joint Administrative ules Committee	Restricts the Department of Health & Social Services from adopting certain rules concerning the provision of psychotherapy under medical assistance.	Oppose	Indefinitely Postponed in Senate.
ase Management B1180/Joint Finance Commit- ee (Budget Review Bill)	Requires the Department of Health & Social Services to submit, by September 1, 1980, to the Joint Finance Committee and other appropriate legislative committees a report on a case management program for medical assistance.	Monitor	Law. (Chapter 221, Laws of 1979.)
ost Reports B1180/Joint Finance Comm. Budget Review Bill)	Authorizes the Department of Health & Social Services to require cost reports from nursing homes and hospitals for purposes of rate certification under medical assistance.	Monitor	Law. (Chapter 221, Laws of 1979.)
econd Opinions B1180/Joint Finance Comm. Budget Review Bill)	Requires second opinions for selected surgical procedures under medical assistance. The Department of Health & Social Services is required to notify providers on types of procedures. The second opinion program terminates June 30, 1982, unless recreated by the legislature.	Monitor	Law. (Chapter 221, Laws of 1979.)
hysician Reimbursement B1180/Joint Finance Comm. Budget Review Bill)	Requires the Department of Health & Social Services to study the fee reimbursement schedules under medical assistance and to submit a report to the legislature by September 1, 1980, on methods to provide greater uniformity for physician reimbursement.	Support	Law. (Chapter 221, Laws of 1979.)

HEALTH EDUCATION

Bill/Sponsors	Synopsis	SMS Position	Final Status
uition B42/Sen. Lorge (R-Bear Creek)	Prohibits Wisconsin resident tuition at the Medical College of Wisconsin from being higher than tuition charged at the University of Wisconsin Medical School.	Monitor	Died in Education & Revenue Committee.
ptometry Schools B149/Education & Revenue ommittee	Provides state funding to contract for resident student spaces in colleges of optometry in other states. If the student practices in a vision care need area upon returning to Wisconsin, the state will reimburse tuition costs.	Oppose	Died in Joint Finance Comm.
B331/Rep. Barry (D-Mount Horeb)	Same as SB149.	Oppose	Died in Joint Finance Comm.
B903/Rep. Dorff (D-Kenosha)	Same as SB149 and AB331.	Oppose	Died in Education Comm
oan Forgiveness Program B79/Joint Finance Comm. Biennial Budget Bill)	Establishes a medical student loan and forgiveness program at Wisconsin's two medical schools. Up to 12½% not to exceed $2,500 of loan may be forgiven annually for four years if the physician practices primary care in Wisconsin. Additionally, 12½% not to exceed $2,500 of loan may be forgiven annually for 4 years if the physician practices any specialty in an underserved area of Wisconsin. The loans are funded through revenue bonding; the forgiveness is funded through increased tuition at the medical schools.	Support forgiveness. No position on tuition increases.	Law. (Chapter 34, Laws of 1979.)
pitation Support 1180/Joint Finance Comm. udget Review Bill)	Revises state capitation support for state residents from 75% of enrollment to 62% at the Medical College of Wisconsin. Capitation is maintained for the same number of state residents as before (496), but the percentage is lower due to increased class size.	Monitor	Law. (Chapter 221, Laws of 1979.)

HEALTH EDUCATION

Bill/Sponsors	Synopsis	SMS Position	Final Status
Family Practice Program AB1180/Joint Finance Comm. (Budget Review Bill)	Provides state funding to the Medical College of Wisconsin for development of a family practice program in the Kenosha area.	Monitor	Law. (Chapter 221, Laws of 1979.)
Nursing Study AB1180/Joint Finance Comm. (Budget Review Bill)	Requires the Department of Health & Social Services to examine the final report of the Wisconsin Statewide Study of Nursing and Nursing Education (SSNNE) and to present their recommendation to the legislature by February 1, 1981. SSNNE recommendations may not be implemented prior to six months after the Department submits its report.	Support	Law. (Chapter 221, Laws of 1979.)

MISCELLANEOUS ISSUES

Bill/Sponsors	Synopsis	SMS Position	Final Status
Tax Exemptions SB13/Sen. Van Sistine (D-Green Bay)	Exempts from the sales and use tax mechanical devices used to aid breathing, if prescribed by a physician.	Monitor	Died in Joint Survey Comm. Tax Exemption
AB72/Rep. Hasenohrl (D-Marshfield)	Exempts from the sales tax supplies used by patients in the treatment of diabetes.	Monitor	"
AB523/Rep. Merkt (R-Mequon)	Same as AB72.	Monitor	"
AB195/Rep. Barczak (D-Milwaukee)	Exempts from the property tax air conditioning or other environmental control equipment, if necessary to maintain health.	Monitor	"
AB504/Rep. Behnke (D-Milwaukee)	Creates a $10 personal tax exemption for each uncompensated voluntary blood donation made by the taxpayer during the taxable year.	Monitor	"
AB1180/Joint Finance Committee (Budget Review Bill)	Exempts from the property tax, real and personal property leased by a hospital from a nonprofit organization if property owned by the hospital qualifies for property tax exemption and the leased property is used exclusively for patient care and treatment.	Monitor	Law. (Chapter 221, Laws of 1979.)
Administrative Rules SB79/Joint Finance Committee (Biennial Budget Bill)	Establishes legislative disapproval powers, prior to promulgation, of state agency administrative rules.	Support	Law. (Chapter 34, Laws of 1979.)
Indigent Patients SB74/Human Services Committee	Requires patients eligible for local relief to apply to the county or municipality liable for the cost of emergency treatment within 30 days of discharge from hospital. The hospital has the burden of proving compliance with this requirement should the local relief agency contest its liability.	Oppose	Died in Human Services Comm
SB184/Human Services Committee	Repeals an existing law requiring local relief agencies to pay the cost of emergency care rendered to indigents.	Oppose	Died in Human Services Comm
SB185/Human Services Committee	Permits county hospitals to provide care for indigent persons and to bill state for one-half of the costs. Present law requires treatment to be rendered at University of Wisconsin Hospitals and Clinics, with the state and the county where the patient resides splitting costs of treatment.	Monitor	Died in Human Services Comm
AB842/Rep. Czerwinski (D-Milwaukee)	Authorizes indigents in Milwaukee County to select the Milwaukee County Medical Complex, or other Milwaukee hospital approved by the Director of Public Welfare, for medical treatment, rather than requiring them to receive treatment at the University of Wis. Hospitals or Clinics. Costs of treatment to be shared equally by Milwaukee Co. and the State.	Monitor	Died in H&SS Committee.

MISCELLANEOUS ISSUES

Bill/Sponsors	Synopsis	SMS Position	Final Status
Fees SB79/Joint Finance Comm. (Biennial Budget Bill)	Establishes a minimum cost of $2,500 for hospital construction and remodeling projects before the Department of Health & Social Services may assess a plan review fee. Present law requires a $200 fee for projects under $25,000.	Support	Law. (Chapter 221, Laws of 1979.)
AB417/Rep. Klicka (R-Wauwatosa)	Reduces annual X-Ray registration fee on radiation equipment to $5 for all types. (Presently varying fees up to $150.)	Monitor	Died in Revenue Committee.
AB420/Rep. Klicka (R-Wauwatosa)	Repeals the requirement that the Department of Health and Social Services charge health specialty laboratory certification fees.	Monitor	Died in Revenue Committee.
AB425/Rep. Klicka (R-Wauwatosa)	Repeals application fee for certificate of need issued by the Department of Health and Social Services for health care institutions and health care projects.	Support	Died in Revenue Committee.
AB1180/Joint Finance Comm. (Budget Review Bill)	Increases the application fees under certificate of need from.2% to .37% of project costs, with the minimum fee increasing from $100 to $200 and the maximum fee increasing from $15,000 to $37,000. In addition, increases minimum certificate of need requirement from $100,000 to $117,000 for capital expenditures and single pieces of medical equipment.	Monitor	Law. (Chapter 221, Laws of 1979.)
Hospital Accreditation SB331/Sen. Bear (D-Madison)	Allows the standards imposed by the Joint Commission on Accreditation of Hospitals for the construction, maintenance and operation of hospitals to be used in lieu of the duplicative standards imposed by the state in accrediting hospitals.	Support	Died in Human Services Comm.
Parental Liability SB378/Sen. Berger (D-Milwaukee)	Authorizes a minor to bring a negligence action for compensatory damages against parents for injuries suffered due to immunization deficiencies.	Oppose	Died in Human Services Comm.
Hospital Boards SB453/Sen. Radosevich (D-North Hudson)	Authorizes a County Board Supervisor to serve as a member of a joint county-city or county-village hospital board.	Monitor	Passed Senate. Died in Local Affairs Comm.
Health Planning Areas SB530/Sen. Cullen (D-Janesville)	Places all of Racine County in the south central health planning area of the southeast Wisconsin Health Services Area. Presently, western portion of Racine County is located in the southwest health planning area of the southeast Health Services Area.	Monitor	Died in Joint Finance Comm.
AB1158/Rep. Porter (R-Burlington)	Same as SB530.	Monitor	Died in H&SS Committee.
Ambulance Attendants AB555/Rep. Matty (R-Crivitz)	Authorizes a city, village, or town, with a population of 15,000 or less, and operating an ambulance service, to substitute a person trained in the American Red Cross standards for advanced first aid for one of the attendants required to be present on an ambulance run.	Monitor	Died in H&SS Committee.
Provider-Patient Privilege AB1180/Joint Finance Comm. (Budget Review Bill)	Includes chiropractors in existing statutes, previously limited to physicians and psychologists, which deal with the provider-patient privilege on communication and information confidentiality.	Oppose	Law. (Chapter 221, Laws of 1979.)
School Absences AB1180/Joint Finance Comm. (Budget Review Bill)	Allows schools to accept certification from dentists, chiropractors and optometrists in excusing children from school for health reasons. Previous law was limited to physicians, psychologists and Christian Science practitioners.	Oppose in part	Law. (Chapter 221, Laws of 1979.)

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Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of September 25, 1980

NEW MEMBERS

COUNTY MEDICAL SOCIETY

BARRON-WASHBURN-BURNETT

Pelant, Thomas M, Rt #2, Box 52-2, Rice Lake 54868 (1944, Regular, Radiology, Certified)

DANE

Brungard, Karen R, 30 South Henry St, Madison 53703 (1951, Regular, Internal Medicine)
Gonnering, Russell S, 7433 Old Sauk Rd, Apt 10, Madison 53717 (1949, Regular, Ophthalmology)
Laxova, Renata, 1500 Highland Ave, Madison 53706 (1931, Regular, Pediatrics)
Lechmaier, Timothy E, 1313 Fish Hatchery Rd, Madison 53711 (1950, Regular, Internal Medicine)
Luyet, Francois M, 30 South Henry St, Madison 53703 (1943, Regular, Pediatrics, Certified)
Millis, Gregory B, 1517 Rae Lane, Madison 53711 (1943, Resident, General Surgery)
Priest, Geoffrey R, 30 South Henry St, Madison 53703 (1950, Regular, Internal Medicine/Pulmonary Diseases, Certified -IM)
Rogerson, John S, 4421 Winnequah Rd, Monona 53716 (1949, Regular, Orthopedic Surgery, Certified)
Toussaint, Norbert F Jr, 6411 Bridge Rd, Apt 201, Madison 53713 (1949, Regular, Ophthalmology)
Zoellner, Gary B, 30 South Henry St, Madison 53703 (1949, Regular, Orthopedic Surgery)

SAUK

Midthun, Thomas T, 703 14th St, Baraboo 53913 (1949, Regular, Family Physician, Certified)

WAUKESHA

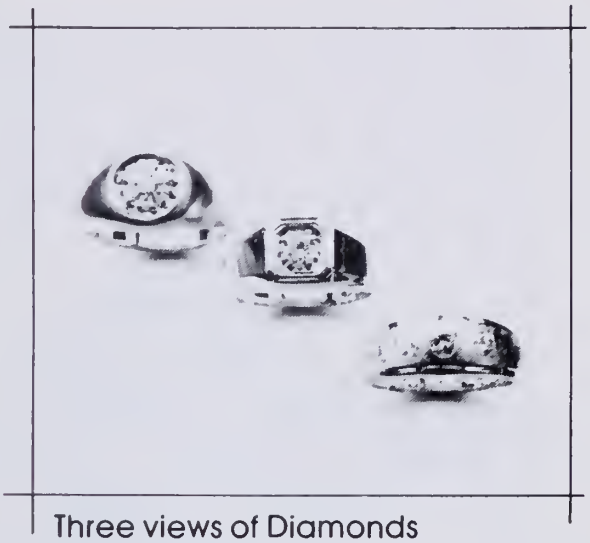
Arnold, Kevin J (DO), 434 Madison St, Waukesha 53186 (1951, Resident, Family Physician)
Gage, Robert B, 434 Madison St, Waukesha 53186 (1952, Resident, Family Physician)
Gershan, Robert N, 8107 Lake Dr, Fox Point 53217 (1950, Regular, Internal Medicine, Certified)
Russo, Mark H Gia, W180 N7950 Town Hall, Menomonee Falls 53051 (1945, Regular, Neurology/Internal Medicine, Certified-IM)
Giles, Steven A, 434 Madison St, Waukesha 53186 (1951, Resident, Family Physician)
Johnson, Dale A, 434 Madison St, Waukesha 53186 (1952, Resident, Family Physician)
Lindeman, Lawrence A, 434 Madison St, Waukesha 53186 (1954, Resident, Family Physician)
Merry, Steven L, N84 W16889 Menomonee, Menomonee Falls 53051 (1949, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)
Schroeder, George S, 434 Madison St, Waukesha 53186 (1953, Resident, Family Physician)

COUNTY-TO-COUNTY TRANSFER

Milwaukee to Ozaukee: McManus, Douglas B, 1575 Parkview Lane, Port Washington 53074
Milwaukee to Waukesha: Wood, Donald L, 17400 W North Ave, Brookfield 53005
Portage to Brown: Barkow, Kathleen M, 1181 Porlier St, Green Bay 54301

DEATHS

Owen, John D, Milwaukee County, Sept 1980 ■



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Obituaries

☐County, State, AMA Members

☐**Jack B Wilets, MD,** 80, Fox Point, died Aug 27, 1980 in Milwaukee. Born Dec 29, 1899 in Milwaukee, Doctor Wilets graduated from Marquette University School of Medicine in 1924. He served his internship and residency at Mt Sinai Medical Center in Milwaukee. Doctor Wilets served in the United States Army Medical Corps from 1944-1945. He also was chief-of-staff at Family Hospital from 1949-1959. He was a diplomate for the American Board of Abdominal Surgery, fellow of the American College of Surgeons, and a member of the Milwaukee Academy of Surgery. He retired from medical practice in 1976. Surviving are his widow, Esther; three daughters, Mrs Kenneth (Elaine) Berke, Fox Point; Mrs Jordan (Joyce) Lewis, Evanston, Ill, and Mrs Gerald (Jacquelyn) Miller of Northridge, Calif.

☐**Charles E Pechous, Sr, MD,** 83, Kenosha, died Sept 13, 1980 in Kenosha. Born on Oct 5, 1896 in Chicago, Doctor Pechous graduated from Loyola University Stritch School of Medicine, Chicago, in 1926. He completed his internship and residency at Cook County Hospital in Chicago. In 1963 Doctor Pechous received the Stritch Golden Medical Award from Loyola University. He had been on the medical staffs of both St Catherine's and Kenosha Memorial hospitals, and president of the former. He also served as president of the Kenosha County Medical Society and was a former councilor of the State Medical Society of Wisconsin. Surviving is his son, Charles E Pechous, Jr, MD of Kenosha.

☐**John Dale Owen, MD,** 73, former Milwaukee physician, died in September 1980 in Phoenix, Ariz. Born Oct 2, 1906 in Phillips, Doctor Owen graduated from the University of Wisconsin Medical School, Madison, in 1931. He served his internship and residency at Long Island College Hospital, Brooklyn, New York. Doctor Owen was a fellow of the American College of Surgeons and was formerly chief of the Department of Obstetrics and Gynecology at St Mary's Hospital in Milwaukee. He retired from medical practice in 1966 and moved to Cave Creek, Arizona where he was instrumental in setting up emergency medical training in Arizona and directed the program for more than seven years. Surviving is his widow.

John M Bell, MD

☐**John M Bell, MD,** 70, Marinette, died Oct 1, 1980 in Cleveland, Ohio. Born May 30, 1910 in Peshtigo, Doctor Bell graduated from Marquette University School of Medicine in 1935 and served his internship at Milwaukee County General Hospital. He practiced medicine in Peshtigo from 1938 to 1951 when he became associated with the Marinette Medical Clinic.

Active in affairs of the State Medical Society of Wisconsin, Doctor Bell served as a councilor from the Eighth District from 1946-1965. He was a member of the Council's Executive Committee, Scientific Committee, and the Audit and Budget Committee. From 1962-1965 he served as vice-chairman of the Council. Doctor Bell was an alternate delegate to the American Medical Association from 1959-1963 and was then a delegate from 1963-1976. He received the Society's Civic Leadership Award in 1972.

Doctor Bell had served as president, secretary, and treasurer of Marinette-Florence County Medical Society and also was Wisconsin chairman of National Conference of County Medical Society Officers in 1950. He had been a trustee of Interstate Postgraduate Medical Association since 1961.

Doctor Bell was a member of the board of directors of the Northeastern Wisconsin Health Planning Council, member of the Regional Advisory Group of Wisconsin Regional Medical Program, and on the medical staff of Marinette General Hospital. He also had served as president of the medical staff of St Joseph-Lloyd Hospital in Menominee, Mich.

Surviving are his widow, Irene; four sons, John, Milwaukee; Stephen, Washington, DC; Peter, Chicago, and Patrick of Green Bay; four daughters, Mary Margaret, Chicago; Kathleen Anne, Corvallis, Ore; Elizabeth, Boston, Mass, and Eileen of Milwaukee. ■

Contributions

to the

CES Foundation

of the State Medical Society of Wisconsin

provide support to the following:

- **Student loans**
- **Charitable assistance**
- **Medical student externship program**
- **Research activity**
- **Continuing medical education**

OPPORTUNITIES FOR GIVING. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Gifts may be unrestricted, restricted, or earmarked for specific purposes of interest to the donor.

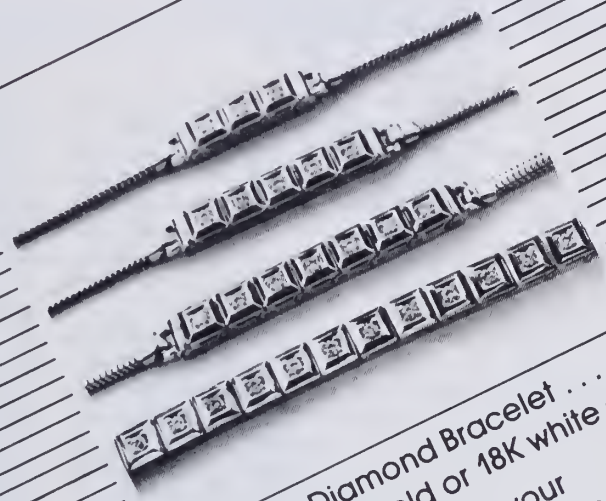
CONTRIBUTIONS ARE TAX-DEDUCTIBLE
Checks should be made payable to: CES Foundation, and sent to CESF, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

Medical Services Conference December 6, San Francisco

The American Medical Association's 1980 Medical Services Conference will be held on Saturday, December 6, at the San Francisco Hilton in conjunction with the AMA's 1980 Interim Session in San Francisco. The conference will examine three important issues impacting on physicians' practices in the 1980s: physician responses to the growth of HMOs, the increased use of cost-effectiveness criteria in decisions about new medical technology, and the impacts on the profession of implementing new appropriateness review and certificate-of-need provisions of the National Health Planning Law. The conference qualifies for five credit hours in Category I of the AMA Physician's Recognition Award. Physicians interested in further details should contact Nicholas M Griffin, Secretary to the Council on Medical Services at AMA headquarters. ■

DO YOU KNOW a physician with problems of alcoholism, drug abuse, or other difficulties which interfere with his/her abilities to practice medicine?

The State Medical Society of Wisconsin has an Impaired Physician Program developed by the Commission on Mediation and Peer Review. Physicians are urged to consult the Commission through John LaBissioniere at SMS headquarters in Madison: phone 257-6781 or toll-free 1-800-362-9080.



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County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Dane CMS gives grant to child safety program

Dane County Medical Society President Hubert V Moss, MD,* Madison, on October 1 presented two checks totaling $7,000 to the American Red Cross, Dane County Chapter, for its Infant Car Safety Seat Program. The grants will provide the major portion of funding for the program which will provide parents of newborn babies in Dane County with safety tested and approved infant car seats at a nominal cost through a six-month loan program.

The program will be implemented through Madison hospitals and will offer parents the opportunity to take their new baby home, safely in an approved car seat. "We're very enthusiastic about this program and see it as an opportunity not only to help save the lives of children and reduce child injuries caused by automobile accidents but also to create public awareness of child automobile safety and instill the 'safety habit' feeling in parents," Doctor Moss emphasized.

In addition to increasing usage of car seats for infants, Doctor Moss hopes the program will help physicians and other medical personnel to appreciate the value of the car seat message and actively encourage usage among their patients.

The following organizations and companies also provided funding for the program: American Family Insurance Group, Viking Insurance Company of Wisconsin, Wisconsin Life Insurance Company, Madison National Life Insurance Company, the Metropolitan Women's Club, and individual contributors.

The Dane County Medical Society Foundation for Medical Research awards grants on occasion to physicians and others engaged in research projects of health or disease, or in the biological behavioral sciences.

The infant car seat loan program began this month and still needs volunteers. Red Cross volunteers explain the program and demonstrate the use of car restraints to new mothers in Madison hospitals. For more information call Lynn Bliss, RN, Red Cross Nursing and Health Services Director, 255-0021.

DANE: The Dane County Medical Society Foundation for Medical Research has issued grants in support of five medical research projects, Hubert V Moss, MD,* Foundation President announced recently.

Kathryn Nichol, MD,* a pediatrician in Madison, received $4,000 from the Foundation to fund research regarding the Infant Car Seat Loan Program, a project shared with the Wisconsin Chapter, American Red Cross.

UW Medical Student Peter Meyer was granted $1,100 to conduct a survey of Dane County physicians about the public's perception of medicine and the effect of recent Dane County Medical Society projects benefiting Dane County residents.

Patricia Joo, MD,* a Madison pediatrician, will be able to conduct research into umbilical cord care in newborn infants, having received a $4,000 Foundation grant.

Terry Oberley, MD,* a Madison pathologist, was awarded $4,000 to begin research into kidney diseases.

John L Atlee III, MD,* an anesthesiologist in Madison, has been awarded $4,000 by the Foundation. He will continue his studies of cardiac irregularities during anesthesia.

The Foundation for Medical Research was established in 1960 to implement the will of Clara M Joss of Madison. In her will, written in 1951, Mrs Joss directed that income from her trust estate be applied "for the uses of medical research."

KENOSHA: At a recent meeting of the Kenosha County Medical Society a seminar on the "Health-related Impact of the Pleasant Prairie Power Plant" proved to be an enlightening, interesting, and altogether successful venture, according to the KCMS secretary, A James Bennett, MD.* In addition to many community leaders and legislators, a large number of interested citizens were in attendance. The KCMS received plaudits from many quarters for demonstrating interest in and providing a forum such as this for discussion of matters of interest to the community, Doctor Bennett reported.

ONEIDA-VILAS: Dr George Sarosi of Minneapolis, Minn was the guest speaker at the September 18 meeting of the Oneida-Vilas County Medical Society held in Rhinelander.

WINNEBAGO: SMS President Russell F Lewis, MD,* Marshfield, was guest speaker at the September 4 meeting of the Winnebago County Medical Society held in Oshkosh. He spoke on affairs of the State Medical Society. Also a guest was SMS Secretary Earl R Thayer, Madison, who offered informal comments and responded to questions. Forty-nine members and seven guests were present.

WINNEBAGO: Thirty-two members of the Winnebago County Medical Society and two guests were present for the meeting on October 2 in Neenah. Brian Jensen, director of the State Medical Society's Physicians Alliance Division, addressed the group on "Politics in 1980 and Budget 1981-1983."

CLARK: Phillip M Green, MD,* of Marshfield spoke to the Clark County Medical Society October 20 in Loyal on the topic, "Neurological Evaluation of the Patient in Coma."

ROCK: Betty J Anderson, counselor in the Legal Department of the American Medical Association, Chicago, addressed the Rock County Medical Society at its meeting September 23 in Janesville.

OUTAGAMIE: Thirty-four members of the Outagamie County Medical Society met September 19 at Appleton where they heard Robert Lapin, MD speak on "Current Status of Prophylaxis and Treatment of Pneumococcal Disease." Doctor Lapin is associate professor of medicine at the Albert Einstein College of Medicine. Brian Jensen, director of the State Medical Society's Physicians Alliance Division, presented information on the Governor's 4.4% state budget cut and its impact on Medicaid reimbursements. A letter from the County Clerk concerning premarital examinations was discussed.

DANE: Dane County Medical Society President Hubert V Moss, MD,* has announced the availability of a service to provide Medical Society physicians as speakers on a variety of medically related subjects. Doctor Moss explained that the service will have a two-fold purpose. "Under this new program," he said, "Dane County Medical Society members will accept requests to address medical groups with the intent to broaden continuing medical education. The second purpose is to provide various clubs and other groups with opportunities to arrange for physician speakers on medical and health matters of interest to people in the Dane County area." Groups which are interested may request the Dane County Speaker Service Roster by writing to the Society at Box 1109, Madison, Wis 53701.

DANE: While conducting a telephone survey of Dane County Medical Society members and nonmembers, under a project grant from the DCMS Foundation for Medical Research this summer, medical student Peter Meyer asked whether legislative representation by organized physician groups such as the Physicians Alliance is important to them. Sixty-four percent of members contacted indicated that this activity is "very important." The Physicians Alliance is a division of the State Medical Society of Wisconsin.

DANE: An open meeting of the Dane County Medical Society September 23 was held at the Methodist Hospital Retirement Center in Madison. Arnold L Brown, MD,* dean of the University of Wisconsin Medical School addressed the group on the subject, "Strengthening Ties Between Town and Gown Medicine."

WAUKESHA: SMS President Russell F Lewis, MD,* Marshfield, was the guest speaker at the September 3 meeting of the Waukesha County Medical Society. He discussed the HMO concept and other organizational matters. ■

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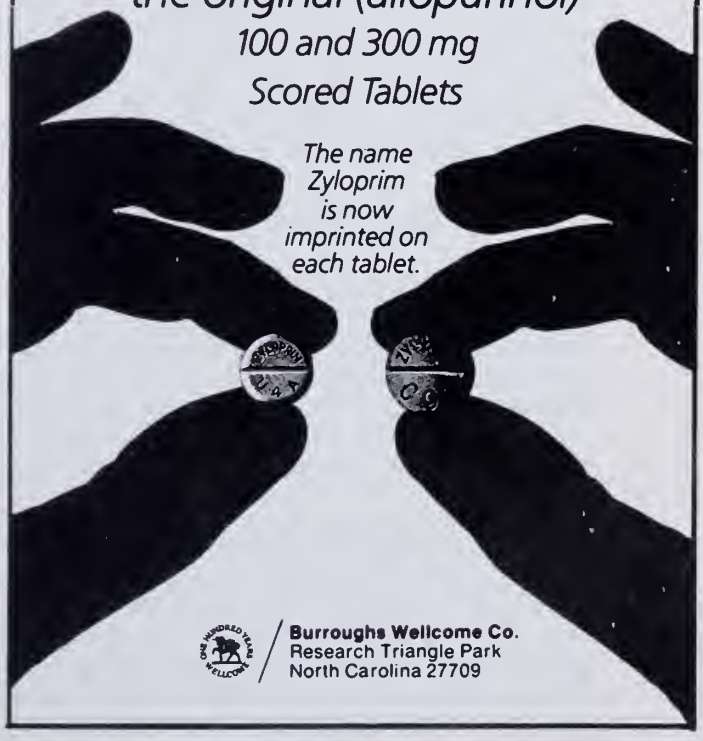

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Specialty Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Milwaukee Academy of Medicine met October 21 at the University Club of Milwaukee. John D Baxter, MD, director of the Endocrine Research Division of the University of California-San Francisco, spoke on "Recombinant DNA and Medical Progress: A Story of Genes and Hormones." The 4th Annual Distinguished Achievement Award meeting of the Academy will be held on November 18 at the University Club. Mortimer M Bortin, MD* of Mt Sinai Medical Center, Milwaukee, will be the recipient.

Wisconsin Neurological Society met October 25 at Lake Lawn Lodge in Delavan. The following papers were presented the first day: *Neuroleptic Malignant Syndrome: A Case Report,* by Doctors VK Saxena, AR Sulaiman, W Ross, and M Klink, Milwaukee; *Late Onset Rod Myopathy with Chronic Neuropathy: A Case Report,* by Doctors AR Sulaiman, MP McQuillen,* HA Abdul Majid, J Baruah, and RH House,* Milwaukee; *Basal Skull Metastasis Presenting as Facial Pain,* by Doctors KE Shewmake and GG Celesia,* Madison; *Double Contrast Dosage CT in the Detection of Adult Metastatic Brain Lesion,* by Doctors D Kaufman and GG Celesia,* Madison; *Lumbosacral Plexopathy: The Role of CT Scan and EMG-NCV Studies in Diagnosis,* by Doctors W Wong, J Barruah, V Saxena, and M Mitz, Milwaukee; *Inverse Ocular Bobbing,* by Doctor HS Schutta, Madison; *Neuropsychological Evaluation of Plasmapheresis and Immuno-Suppressive Drug Therapy in Multiple Sclerosis: A Report of a Case,* by Doctors SM Rao, MP McQuillen,* BO Khatri, and TA Hammeke, Milwaukee; *Some Clinical Aspects of Huntington's Disease,* by Doctor N Reynolds, Milwaukee; *Electrode and Neuropsychological Testing in Huntington's Disease,* by Doctors P Hansotia* and G Taylor,* Marshfield; and *Choreo-athetosis in Children,* by Doctor S Linsmeister. A Seminar on Extrapyramidal Diseases, entitled *Parkinson's Disease: New Developments and Old Problems,* was presented by Doctor HL Klawans of Chicago. The luncheon speaker was Doctor I Stanko* who spoke on *Medical Practice in Czechoslovakia.* The second day's program dealt with Electro-diagnosis. Papers included *The Problem of Thoracic Outlet Syndromes,* by Doctor I Stanko*; *The Blink Reflex,* by Doctor D Frens*; and *BAERS in Newborns and Children,* by Doctor K Hecox. Gastone G Celesia, MD* is Secretary for Medical Education of the Wisconsin Neurological Society.

American Academy of Family Physicians (AAFP) cited four scientific exhibits at the 1980 World Conference on Family Medicine held October 6-9 in New Orleans. The AAFP Committee on Scientific Program recognized the exhibits for outstanding format, appearance, and educational value. Two of the four cited were Wisconsin exhibits: *Plastic Pearls and Other Surgical Gems* from St Francis Hospital and St Francis-Mayo Family Practice Residency, LaCrosse, by Doctors Margaret Behrens, Martha Hickner, Mark Connelly, and William E Davis.* *Creatures That Bite in the Night* by Stephen B Webster, MD,* Diane M Uhler, RN, and Donna L Myer, all of LaCrosse. Some 5500 family physicians participated in the world conference on family medicine—first of its kind to be held in the United States. The conclave was cosponsored by the AAFP and WONCA (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians). ■

NEWS YOU CAN USE

PROGRESS IN PATHOLOGY. The State Department of Health and Social Services finally has agreed to accept the accreditation program of the American College of Pathology in lieu of its own inspection/accreditation activity. SMS and the Wisconsin Society of Pathologists have sought this recognition for several years, as permitted by Wisconsin law. This will remove one area of expensive duplication in the laboratory licensing program in Wisconsin.

PATIENT EDUCATION FLYERS AVAILABLE. Copies of the new SMS mini-brochure, *Make Yours a Smokeless Pregnancy,* are available in quantity to SMS physicians. A valuable patient education piece, this brochure is suited to insertion in patient mailings or placement in MD office reception areas. It was prepared by the SMS Commission on Public Information and Committee on Maternal and Child Health with support from the Wausau Insurance Companies. Other mini-brochures on the topics of Rubella and Fetal Alcohol Syndrome also are available to Society physicians in quantity. Contact SMS Communications Dept, 257-6781 or 1-800-362-9080 toll-free. ■

Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Manjeet K Bouri, MD, recently joined the medical staff of the Gundersen Clinic, LaCrosse, in the Department of Psychiatry. She graduated from Christian Medical College, Ludhiana, India, where she also served her internship. From 1971-73 she attended the Institute of Medical and Research in Chandigarh, India. Doctor Bouri served her residency at the University Hospitals of Cleveland and Case Western Reserve University.

John S Rogerson, MD,* Madison, recently became associated with MDs Jack D Heiden* and George H Vogt* in the practice of orthopedics. He graduated from the University of Iowa at Iowa City and served his internship in Sioux Falls, SD. His residency in orthopedics was served at the University of Wisconsin Medical School, Madison.

Richard L Campbell, MD, Sheboygan, recently joined the medical staff at St Nicholas Hospital. Doctor Campbell graduated from the University of Wisconsin Medical School, Madison, in 1976 and served his internship at Hennepin County Medical Center in Minneapolis. His residency in radiology was completed in the University of Minnesota Hospitals.

Stephen L Griswold, MD and **Juan B Lopez, MD** recently became associated with the medical staff of the Rice Clinic, Stevens Point. Doctor Griswold graduated from the University of Kansas and completed his residency in internal medicine at St Luke's Hospital, Kansas City, Mo. Doctor Lopez graduated from the University Autonoma of Guadalajara, Mexico, and completed his residency in pediatrics at the Winnipeg Children's Hospital and the University of Manitoba in Canada. He then took a two-year fellowship in neonatology at the Medical College of Wisconsin and Dalhousie University in Halifax, Nova Scotia, Canada.

Meena Maski, MD, Platteville, recently joined her husband, Ravikant Maski, MD, in practice at Doctors Park. Doctor Maski graduated from medical school in India in 1968. She served her residency in pediatrics at St Peter's Hospital in Albany, NY and at Hartford General Hospital, Hartford, Conn. Prior to coming to Platteville, Doctor Maski had been in practice in Elmira, NY.

Julio Davila, MD,* cardiovascular surgeon with the A Ward Ford Memorial Institute and Wausau Hospital Center, recently conducted postgraduate courses for heart surgeons, cardiologists, and medical practitioners in Brazil. He gave lectures on heart valve replacement and coronary artery surgery at Heart Hospital in Rio de Janeiro.

John J Colgan, MD,* Eagle River (left) is shown above receiving an engraved Golden Hour Clock from sales representative Mr Byron Zanella (right) of Abbott Laboratories. Abbott Laboratories presented Doctor Colgan the clock for his 50 years of outstanding service and dedication to medicine.

Don Christensen, MD, Washburn, recently joined the medical staff of the Bayfield County Memorial Hospital. Doctor Christensen, who practiced the last seven years in Kotzebue, Alaska inside the Arctic Circle, graduated from the University of Minnesota School of Medicine and served an internship at St Mary's in Duluth.

Peter J Melcher, MD,* Eagle River, recently became associated with the Eagle River Memorial Hospital medical staff. Doctor Melcher is working with George T Anast, MD of Northwoods Rehabilitation Associates in the practice of orthopedic surgery. He graduated from New Jersey College of Medicine and served his residency at the University of Washington.

Mary A Govier, MD, Manitowoc, recently joined the medical staff of the Manitowoc Clinic. Doctor Govier graduated from the University of Missouri Medical School and served her internship and residency at the University of Iowa in Iowa City, Iowa. She is associated with the Department of Internal Medicine at the Clinic.

Charles Lonsdorf, MD, has joined the medical staff of the Lakeland Medical Associates. He graduated from the Medical College of Wisconsin and served his family practice residency at the University of Iowa in Iowa City.

Harry A Easom, MD,* Milwaukee ophthalmologist, recently returned from the Soviet Union where he studied a myopia surgery technique. Doctor Easom was one of 35 US eye specialists who spent time in the Soviet capital observing the operative way of curing myopia, as developed at the Moscow Research Institute of Eye Microsurgery. Doctor Easom is quoted as saying, "I must confess that the reason I came here was more out of doubt than out of real enthusiasm, and I have to say that I was very impressed with the results that I saw and I would have to say that I have really changed my opinion on the operation in a relatively short period of time."

Bryon J Crouse, MD, Spooner, recently began medical practice with S J Carlson, MD at the Family Practice Clinic. Doctor Crouse graduated from the Mayo Medical School, Rochester, Minn, and completed his residency at the Duluth Family Practice Center.

Thomas P O'Malley, MD, * was named chairman of the State Health Policy Council. Doctor O'Malley graduated from Loyola University School of Medicine. He has been on the medical staff of the Rice Clinic, Stevens Point, since 1968.

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Joan M Gennrich, MD,* Milwaukee, recently was recognized by the McDonald's Corporation for her service to the community, during grand opening ceremonies for the corporation's newest operation. Doctor Gennrich is medical director and founder of the Bradley Medical Center; reportedly Wisconsin's first free-standing emergency care facility. She is a member of the Emergency Medical Services Committee of the Medical Society of Milwaukee County and is on the board of directors of the Wisconsin Chapter of Emergency Physicians. Doctor Gennrich is shown above cutting the ceremonial ribbon during the opening of the new Northridge Mall McDonald's restaurant. LEFT TO RIGHT: Kitty Radcliffe, Joan Gennrich, MD; Ronald McDonald, and Scott Thomas. (Ms Radcliffe and Mr Thomas are members of the Northridge Mall Merchants Association.)

Phiroze L Hansotia, MD* and **Samuel Idarraga, MD*** were faculty members for the one-day conference on *Stroke Rehabilitation: A Comprehensive Team Approach,* presented by St Joseph's Hospital and the Marshfield Clinic, Marshfield, November 1 at the clinic conference center. The program was designed for physcians, registered nurses, licensed practical nurses, physical and occupational therapists, social workers, speech pathologists, community health professionals, and other healthcare professionals who wished to explore the multidisciplinary approach to the treatment and counseling of the stroke patient and family. Doctor Hansotia is a neurologist in the Neurosciences Department of the Marshfield Clinic; Doctor Idarraga is a physiatrist in the Physical Medicine and Rehabilitation Department of the Marshfield Clinic.

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Sidney E Johnson, MD* has been reelected medical director of the Marshfield Clinic. A Board-certified internist and gastroenterologist, Doctor Johnson became medical director in 1977. Under Doctor Johnson's leadership, physician recruiting became a successful program for Clinic facilities in Marshfield, Ladysmith, Stanley, Greenwood, and Mosinee, Clinic officials report. In 1977 Doctor Johnson received the American Medical Association's Recognition Award for Continuing Education.

Rustan Wiersma, MD J Robert Grove, MD, and **James Richardson, MD,** recently became associated with the Skemp-Grandview-LaCrosse Clinic and St Francis Medical Center in LaCrosse. Doctor Wiersma graduated from Loyola University Stritch School of Medicine, Maywood, Ill, and served his residency in otolaryngology at Northwestern University. Doctor Grove graduated from Northwestern University School of Medicine and served his residency in internal medicine at Blodgett Memorial Hospital, Grand Rapids, Mich. He recently completed a cardiology fellowship at the Medical College of Wisconsin, Milwaukee. Doctor Richardson, a family physician, earned his medical degree at the University of Wisconsin Medical School, Madison, and served his residency at St Mary's Hospital, Milwaukee.

Stuart Boismenus, MD, Rhinelander, has joined the W S Bump Medical Group, SC in the Department of Pediatrics. He graduated from the University of Wisconsin Medical School, Madison, and completed his residency training at Children's Mercy Hospital in Kansas City, Mo.

Richard E Gladitsch, MD, Bloomer, recently opened his medical practice at the Blue Diamond Family Practice Center. Doctor Gladitsch graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency in Boise, Idaho. ■

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/ Clinical Practice." ■

News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Todd Wehr Library of the Medical College of Wisconsin (MCW) is seeking to build its archives on the local history of medicine. Health practitioners in southeastern Wisconsin and their families and friends are requested to forward old notebooks, manuscripts, records and other correspondence of a historical nature. At present the project is local only but might be expanded to cover all of Wisconsin. "Such materials could add to the area's medical heritage," MCW Librarian, Bessie Stein, said. This project has the support of the Wisconsin State Archivist and the History of Medicine Librarian, Middleton Health Sciences Library, UW-Madison. No other institution in the state is actively seeking this type of material. Anyone interested in contributing their papers for historical preservation should contact Neil M Hootkin, special collections librarian at the Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wis 53226, or call (414) 257-8337 or 257-8323. MCW is represented on the Library Council of Metropolitan Milwaukee Archives Committee.

Lutheran and Deaconess Hospitals in Milwaukee formally merged their staffs October 1. The merger established the hospital name of Good Samaritan Medical Center, with the Deaconess Hospital address of 620 North 19th Street, Milwaukee, 53233. As reported in the July issue the merger will bring about a new location, probably in the downtown area, within three to four years. Mr Kenneth S Jamron, administrator at Deaconess, is the administrator for Good Samaritan Medical Center.

Blue Cross Blue Shield United of Wisconsin on August 27 elected a new board of directors, including eight physician members. They are: MDs Blake E Waterhouse,* Madison; Adolf L Gundersen,* LaCrosse; James R O'Connell,* Milwaukee; W Carson Parks,* Milwaukee; Chesley P Erwin,* Milwaukee; Joseph C Darin,* Wauwatosa; James D Michael,* Sheboygan; and Enzo Krahl,* Superior.

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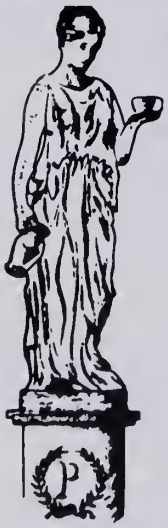

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'QUAGESIC—Abbreviated Summary

•INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient.

ONTRAINDICATIONS: Equagesic should not be given to ividuals with a history of sensitivity or severe intolerance aspirin, meprobamate, or ethoheptazine citrate

ARNINGS: Careful supervision of dose and amounts prenbed for patients is advised, especially with those patients h known propensity for taking excessive quantities of drugs cessive and prolonged use in susceptible persons, e g , coholics, former addicts, and other severe psychoneurot-, has been reported to result in dependence on or habitation to the drug Where excessive dosage has continued weeks or months, dosage should be reduced gradually her than abruptly stopped, since withdrawal of a "crutch" ly precipitate withdrawal reaction of greater proportions in that for which the drug was originally prescribed Abrupt continuance of doses in excess of the recommended dose s resulted in some cases in the occurrence of epileptiform zures

ecial care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with relant slowing of reaction time and impairment of judgement d coordination

AGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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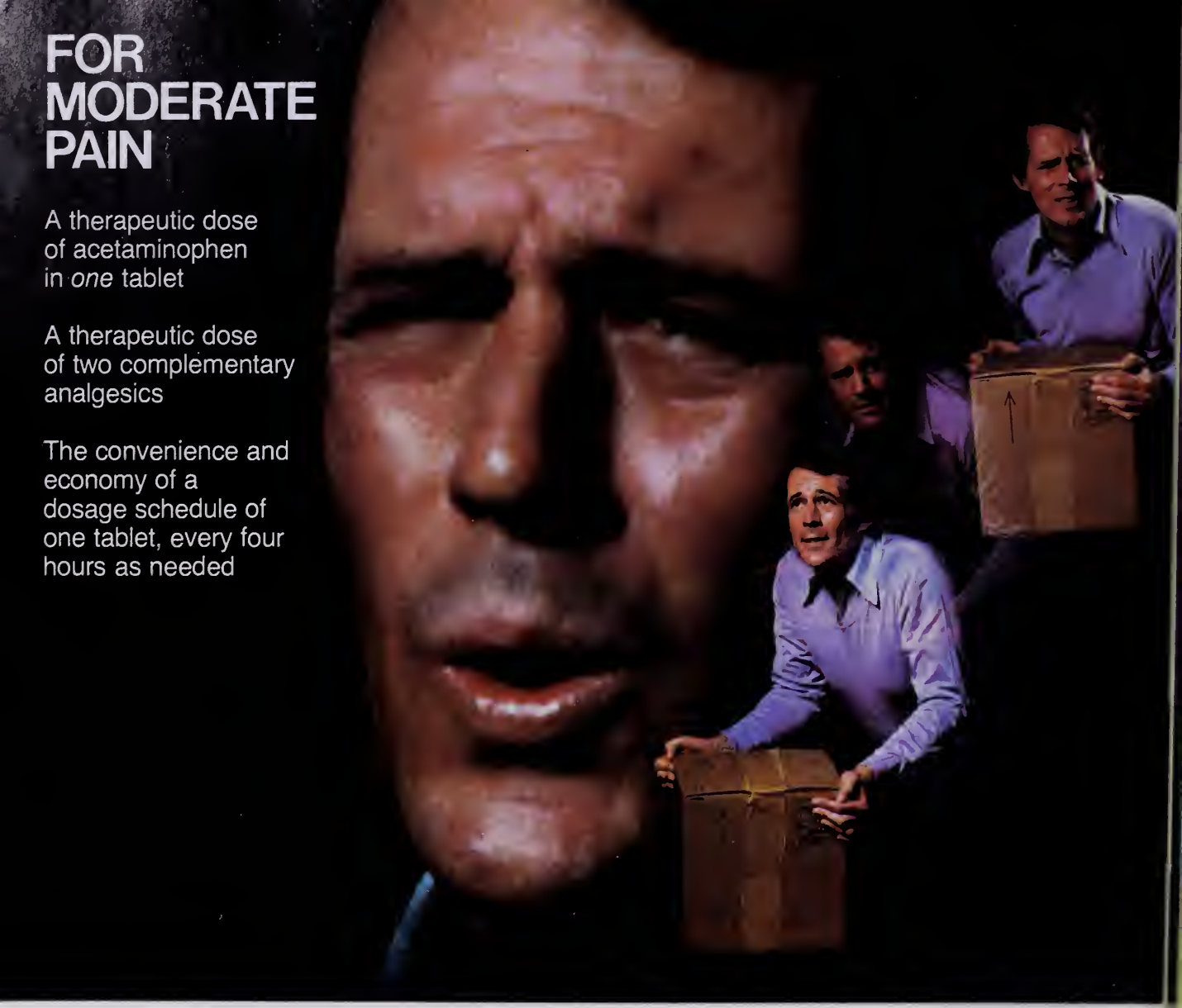

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WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

Rheumatologist wanted to join four orthopedic surgeons in a very desirable north central Wisconsin community with a drawing population of 70,000. Active practice assured, shared "on call" provided, research grants available. New Clinic facility located within new 35 million dollar hospital complex. Outstanding personal benefit programs, generous guaranteed income. For further information contact: Lloyd Engstrom at 715/842-3202, or write PO Box 1646, Wausau, Wis 54401. 8-12/80

Family Practitioner wanted: 13-man, mixed group practice seeking family practitioner to join its Family Practice Department of six family practitioners located 100 miles south of the Twin Cities in a community of 25,000. Ideal community with excellent schools and multiple recreational opportunities, new hospital. Liberal benefits and top salary offered. This is a choice practice opportunity in rural southern Minnesota. Please contact James Burns, MD, 210 N St Mary St, Albert Lea, Minn 56007. Phone: 507/373-1441. 10-12/80

Medical Emergency Service Associates (MESA), SC, has an immediate opening for a full-time emergency physician at a hospital in Rockford, Ill. MESA offers a computed salary up to $85,000 annually, excellent working conditions, flexible scheduling and fringe benefits plus the opportunity to join a stable growing corporation dedicated to providing quality emergency medical services. MESA will also consider negotiating relocation expenses. Send your CV or phone MESA, 15 South McHenry Rd, Suite 2, Buffalo Grove, Ill 60090; Mrs Barten (312/459-7300) MESA would like to be a part of your future. 11-12/80

Family Practitioner wanted to locate in an expanding family practice satellite associated with a large multispecialty clinic in east central Wisconsin. Guaranteed salary plus liberal incentive benefits, profit sharing, and many other advantages of a large incorporated medical group. For more information please send resume and CV to M V Mutzelburg, Manager, Fond du Lac Clinic, SC, 80 Sheboygan Street, Fond du Lac, Wisconsin 54935. 11-12/80*

Fifty-physician multispecialty clinic in West Central Wisconsin wants allergist, cardiologist (noninvasive), pediatrician, and family practitioner to do acute medicine. Also family practice openings in nearby satellite offices. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Admin, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5266. 9-12/80

Dermatologist desires partnership, group association or solo location in Wisconsin or Minnesota. Board certified. Experienced surgery, PUVA and x-ray therapy. Contact Dept 485 in care of the Journal. p11-12/80,1/81

The Nicolet Clinic, SC, a young progressive 33 physician multispecialty group, has superb opportunities available for the practice of:

- Nephrology
- Ophthalmology
- Family Practice
- Radiology

Ideal family oriented community in metropolitan area with excellent schools, economy, culture, and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued medical education. Contact in confidence Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Phone: 414/727-4244. 11-12/80,1-2/81

Wisconsin locum tenens available. Family practice, can do OB and ER. High productivity. Write: Locum Tenens, 5695 Merry Lane, Excelsior, Minn 55331. Phone: 612/474-4372. p11-12/80,1-2/81

Emergency Physician. Wausau, Wisconsin. Residency training and/or ER experience required. Fee for service corporation with excellent income and benefits. New facility with excellent backup. Family and sportsman's paradise. Send CV or call: Fred A Klemm, MD, 2404 Hawthorne Lane, Wausau, Wis 54401. Phone: 715/842-9373. p11-12/80,1/81

General Internist: Join an 18-physician multispecialty clinic in Appleton, Wis. Have departments in pediatrics, surgery, family practice, internal medicine and OB/GYN. Need another internist. Excellent hospitals, guarantee and incentive compensation. Complete benefit package. Medium-size community with excellent educational, cultural, recreational, and shopping opportunities. Contact Art Schuetze, Medical Arts Clinic, SC, 401 North Oneida St, Appleton, Wis 54911. Phone: 414/739-0171. 9-11/80

OBSTETRICIANS-GYNECOLOGISTS WANTED

Obstetricians-Gynecologists board certified or eligible wanted to join in practice with obstetrician-gynecologist in a city of 100,000 on Lake Michigan between Milwaukee and Chicago. Excellent schools, medical school affiliation, security of freedom of practice in independent small group. Contact: Elizabeth A Steffen, MD, 734 Lake Ave, Racine, Wis 53404. Phone: 414/637-8311. 6tfn/80

Physicians Exchange

continued

Multispecialty Group of 32 physicians offering practice opportunity to:

- Obstetrician-Gynecologist
- Psychiatrist
- Dermatologist

Attractive income arrangements, association membership within one year, pension, extensive fringe benefits. No personal investment. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081. Tel: 414/457-4461. 11/80

Medical Director for established staff model HMO in south central Wisconsin. Federally qualified primary care clinic with highly qualified specialist consultants. Board certified family practitioner or internist preferred. Experience or training in medical administration and strong leadership qualities required. Competitive salary and benefit program including excellent pension, insurances, CME, etc. All replies confidential. Write to Patrick Brady, Executive Director, Group Health Cooperative of South Central Wisconsin, One South Park St, Madison, Wis 53715 or call 608/251-4156 for appointment. 11-12/80

Relocation opportunities or initial practice in Fox Valley for general internists, family practitioners, and pediatricians. Support of other independent practitioners assured. Excellent schools, recreational area, as well as clinical facilities in JCAH approved hospital. PO Box 801, Neenah, Wis 54956. p11-12/80,1-4/81

Family Practice. General Clinic — Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Internist—Board Certified or Eligible, to join 4 internists, 2 pediatricians, 1 OB/GYN, and general surgeon; clinic building next to community hospital; expanding service area in western Milwaukee metro fringe location; first year salary with optional second year corporate stockholder; excellent fringe benefits including pension and profit sharing plans. Contact James L Algiers, MD or Clinic Manager, 1004 E Sumner St, Hartford, Wis 53027. Phone: 414/673-5745 (Collect). 5tfn/80

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Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN

MEDICAL PROFESSIONAL PLACEMENTS

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Licensed Employment Agency 9tfn/79

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 20-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 7tfn/80

Internist wanted to practice in conjunction with a six-member Internal Medicine Department of a 20-physician multispecialty group, located in the upper Midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen L Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. Phone: 414/632-7521. 8tfn/80

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

Family Practice. Wanted a family practitioner to locate in new clinic building in Poynette, Wis. Located 30 miles from Madison, Wis. Poynette is a village of approximately 1000 with a service area of 7000 persons. Salary guaranteed. Contact John Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 10tfn/80

Racine Medical Clinic, SC, multispecialty group of 20 physicians has a practice association for:

- Family/General Practitioner
- General Surgeon
- Pediatrician

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 9tfn/80

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Locum Tenens work wanted. Family and general practice, open availability. T C Kolff, MD, 801/566-1666. 9-11/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Two-three Board eligible/certified family physician's needed in Northeastern rural Wisconsin. New clinic adjacent to fine 60-bed hospital. Financial assistance available and negotiable. Excellent location, community atmosphere and economy. Contact J Schumacher, Admin, Calumet Memorial Hospital, Chilton, Wis 53014. Phone: 414/849-2386. 10-12/80

Indiana—Fort Wayne: Emergency physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc, 4400 Broadway, Suite 306, Kansas City, Missouri 64111, 816/931-3040. 10-12/80

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Board certified general surgeon desires to relocate in Wisconsin near large city. Wisconsin license. Willing to do some general practice. References upon request. Contact Dept 481 in care of the Journal. 7-11/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Hematology/Oncology
- Otolaryngology

Beautiful new building adajacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

OB-GYN to do gynecology and high-risk OB to join 12 physician primary care practice in northwestern Wisconsin. New 75-bed hospital and new clinic, 100 miles from the Twin Cities. Lester A Thompson, MD, 1020 Lakeshore Dr, Rice Lake, Wis 54868. 10-12/80

Physician wanted to perform light physicals five days per week in the Milwaukee area. Ideal job for retiring physician. Contact Mike Stough, collect, at 513/621-8728. 11tfn/80

Medical Facilities

Office space available in southeastern Wisconsin near 200-bed hospital. Fully equipped, suitable for a Family Practitioner. Metropolitan Milwaukee area. Contact Dept 484 in care of the Journal, or phone 414/965-2200. 10tfn/80

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

8-12/80,1-7/81

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For lease: Approximately 1500 sq ft, furnished or unfurnished, in West Milwaukee, edge of Wauwatosa. 9300 West Capitol Dr, Milwaukee. Perfect for Internist or Family Practitioner. Four exam rooms; consultation, lab, insurance, and waiting rooms. Favorable terms. For further information contact: Phone 414/463-6650. 9tfn/80

For Sale: Zeiss Photomicroscope with circular rotating and centering mechanical stage, automatic exposure device and full power pack. Several objective and ocular lenses. Excellent condition. Regularly maintained by manufacturer's representative. Contact Mr. Bernard Goldstein, 606 West Wisconsin Ave, Milwaukee, Wis 53203. Phone: 414/271-1400. g10tfn/80

For Sale: Professional office building in Milwaukee. Approximately 2700 sq ft presently houses three dentists and hearing aid office. Central air, new roof, private parking area. Excellent tax write off. Very reasonable. Call after 7 pm 414/258-8555. p11/80

For Sale: Optical instruments and equipment of deceased physician. Also ENT equipment, office furniture. Phone: 414/424-4282 during business hours. Oshkosh. 11/80

Equipment for sale: Burdick diathermy machine excellent condition. Remington Rand and Cole File card cabinets. Steelmaster double drawer build-up 4x6 card file cabinets. Best offer accepted. Contact: Wilkinson Clinic, Oconomowoc, Wis 53066. Phone: 414/567-4433, ext 267. 11-12/80

Real Estate

Investment property—Four family—high rents plus laundromat income. On site manager; Random Lake, Wis. $140,000. Phone: 414/351-5457. p11/80

CONSULTANT FOR FLORIDA REAL ESTATE

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Bookshelf

New books received *are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.*

The Professional and Scientific Literature on Patient Education: A Guide to Information Sources. Edited by Lawrence W Green and Connie Cavanaugh Kansler. Gale Research Co, Book Tower, Detroit, Mich 48226. 1980. Pp 130. Price: $28.00.

Review of Medical Pharmacology. By Frederick H Meyers, MD, Ernest Jawetz, MD, PhD, and Alan Goldfien, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1980. Pp 747. Price: $17.50.

Source Book of Health Insurance Data. Health Insurance Institute, 1850 K Street, NW, Washington, DC 20006. 1980. Pp 108.

The American Heart Association Cookbook. By Ruthe Eschelman and Mary Winston. Ballantine Books, 201 East 50th St, New York, NY 10022. 1980. Pp 576. Price: $7.95.

A Layman's Guide to Modern Medicine. By Daniel W Foster, MD. University of Texas Health Science Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235. Pp 398. Price: $14.95.

Medical Self-Care. Edited by Tom Ferguson, MD. The Simon & Schuster Bldg, 1230 Avenue of the Americas, New York, NY 10020. 1980. Pp 320. Price: $19.95.

Current Obstetric & Gynecologic Diagnosis & Treatment. 3rd Edition. By Ralph C Benson, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1980. Pp 1001. Price: $21.00. ■

Announcements

The Cytotechnology program of St Joseph's Hospital in Marshfield is a one-year program that prepares students for laboratory positions which identify cellular changes and assist in diagnosis of cancer and other diseases. Applications for this program are due before March 1. Classes begin in early August of next year. Information and applications are available from Virginia Narlock, Program Director, 611 St Joseph Ave, Marshfield, Wis 54449.

1981 Editions of the *Accreditation Manual for Hospitals (AMH)* and *Hospital Survey Profile (HSP)* now available from Joint Commission

The Joint Commission on Accreditation of Hospitals (JCAH) has recently published the 1981 editions of the *Accreditation Manual for Hospitals (AMH)* and *Hospital Survey Profile (HSP)*.

The 1981 edition of the *AMH*, which will be used for all hospital accreditation surveys conducted in 1981, features the new quality assurance standard for hospitals, an updated administrative policies and procedures section, an appendix that details changes in the standards since publication of the 1980 edition, and an expanded index. The 1981 edition of the *HSP* reflects all changes made in the 1981 edition of the *AMH*.

Each accredited hospital receives a complimentary copy of the 1981 *AMH* upon publication. Copies of the *HSP* are sent to a hospital before its accreditation survey to complete and return to JCAH. Additional copies of each publication may be purchased from JCAH by contacting the Publications Sales Department, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave, Chicago, Ill 60611.

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

JANUARY 2-3, 9-10, 16-17, 1981: *Third Annual Winterum,* University of Wisconsin Medical School, Administrative Medicine Program, 1981 Winter Weekend Studies.

✔ *Management of Medical Education Institutions*—Management practices for medical education institutions, presented in a seminar format. Planning, policy, budgeting, managerial accounting and control, organizational goals, and future changes. Provides students with an analytical framework pertaining to external pressures for cost containment, uses of accounting information for purposes of external financial reporting and internal decision making, and involvement in the institutional budgetary process. Don E Detmer, MD, and Mark Covaleski, PhD, instructors. Class will meet on Fridays from 6:30-9:30 pm and Saturdays from 8:30 am-12 noon and 1:30-4:30 pm.

✔ *Principles of Health Care Education*—Introduction to principles of educational planning, development, implementation, and evaluation as applied to health care delivery settings; administering and supervising an educational program; curriculum development methodologies; principles and strategies of teaching and learning; evaluation of program effectiveness; providing support services for an educational program; identifying learning resources in a variety of health care delivery settings; and the design and implementation of continuing education programs. This is a semi-independent study course with four days of actual classroom activity. January 2 and 16, 6:30-9:30 pm; January 3 and 17, 1:30-4:00 pm.

Participants should provide evidence of leadership ability in the healthcare system. The offerings are available either for credit, audit, and/or CME credit for those with a health professional degree or its equivalent in professional training and certification. For further information on registration, contact Administrative Medicine Office, University of Wisconsin-Madison, Center for Health Sciences, 1225 Observatory Drive, Madison, WI 53706. Phone (608) 263-4889.

JANUARY 12-14, 1981: *New Therapeutics: The Results of Recent Advances in Medicine,* Telemark Lodge, Cable. Sponsored by University of Wisconsin School of Medicine; University of Wisconsin-Extension, Continuing Medical Education. Category I credit of AMA and LCCME. Fee: $210. Info: Ann Bailey, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2854.

JANUARY 15-21, 1981: Fourteenth Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics and Endocrinology,* sponsored by the Medical College of Wisconsin, Milwaukee, at the Pfister Hotel and Tower, Milwaukee. Among guest faculty will be: H W Jones Jr, MD; Georgeanna S Jones, MD; J D Woodruff, MD; and Robert Young, MD (NCI). Approved for 42 cognate hours, Formal Learning, by American College of Gynecologists and meets criteria for 42 hours of credit in Category 1 for the PRA-AMA. Also approved for 42 elective hours of credit by the American Academy of Family Physicians. A $475 enrollment fee will include 68 selected 35mm slides. Registration fee is nonrefundable. Further details and registration, write to: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis. 53226.

JANUARY 18-20, 1981: *Medical/Surgical Update '81,* Telemark Lodge, Cable. Sponsored by Marshfield Clinic and Marshfield Medical Foundation. 9½ credit hours of Category I of the AMA-PRA approved and 9½ hours of prescribed credit of AAFP applied for. Info: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449.

11th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

January 28-30, 1981 at The Pfister Hotel and Tower, Milwaukee, Wisconsin

The Department of Family Practice, The Medical College of Wisconsin, and Southeast Chapter of the Wisconsin Academy of Family Physicians.

This three-day course will explore problems of the Acute Abdomen, Chest Pain, Thyroid Disease, Medical Ethics, and clinical updates in the fields of Radiology, Laboratory Medicine, Pulmonary Medicine, Orthopedics, Urology, and Cardiovascular Medicine. Workshops and lectures constitute the format of this seminar.

Accepted for 19 credit hours Category I AMA-PRA and AAFP

Fee: $160.

Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, Wis 53211. Phone: 414/291-0813.

WISCONSIN continued

JANUARY 23-24, 1981: *First Annual Seminar on Clinical Genetics,* The Wisconsin Center, Madison. Approved 16 credit hours Category 1 of AMA and AAFP. Fee: $190. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone: 608/263-2856.

JANUARY 28-30, 1981: 11th Annual Winter Refresher Course for Family Physicians, The Pfister Hotel and Tower, Milwaukee. Accepted for 19 credit hours of Category I of AMA-PRA and AAFP. Info: Mrs Susanna Rechlitz, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, Wis 53211. Phone: 414/291-0813.

FEBRUARY 24-27, 1981: 8th Annual Endoscopy Conference *"Endoscopic Profile 1981: Assessment of Endoscopic Skills, Diagnostic Acumen and Clinical Judgment",* Pfister Hotel, Milwaukee. Approved for 23 credit hours of Category I of AMA and 23 elective hours of AAFP. Fee: $300. Info: Joseph E Geenen, MD; Walter J Hogan, MD; GI Section, 8700 West Wisconsin Ave, Milwaukee 53226. Phone: 414/291-0813.

FEBRUARY 26, 1981: *Endoscopic Accessories,* Pfister Hotel, Milwaukee. Fee: $125. Info: Ms Marcia Pfeifer, RN, Course Director, Gastroenterology Consultants, Ltd, 1333 College Ave, Racine 53403.

MARCH 1-2, 1981: *5th Annual Winter Pediatric Seminar,* Caribou Lodge, Powderhorn Ski Area, Bessemer, Mich. Approved for 8 credit hours of Category I of the AMA-PRA and AAFP. Fee: $55. Info: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449.

MARCH 19-20, 1981: *5th Annual Ophthalmology Current Concepts Seminar '81,* Sheraton Hotel, Madison. AMA Category I on an hour-by-hour basis. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

MAY 4-6, 1981: *Intravenous-Arteriography.* University of Wisconsin-Madison, Memorial Union, Madison. Approved 16 credit hours Category 1 and 16 hours American College of Radiology. Fee: $395. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone: 608/263-2856.

Section of Gastroenterology, The Medical College of Wisconsin

8TH ANNUAL ENDOSCOPY CONFERENCE "ENDOSCOPIC PROFILE 1981: ASSESSMENT OF ENDOSCOPIC SKILLS, DIAGNOSTIC ACUMEN AND CLINICAL JUDGMENT"

February 24-27, 1981, Pfister Hotel, Milwaukee, Wisconsin

The three-day conference features formal lectures, mini-group demonstrations, panel discussions, TV and motion pictures and exhibits. For the first time, our participants will test their clinical and diagnostic skills, in solving our renowned "teaching cases."

Guest Faculty: *H Worth Boyce, MD,* Tampa, Fla; *Thomas Ihre, MD,* Stockholm, Sweden; *John LoGiudice, MD,* Oak Park, Ill; *Lazlo Safrany, MD,* West Germany; *Fred Silverstein, MD,* Seattle, Wash; *Robin H Teague, MD,* Liverpool, England; *Francis Tedesco, MD,* Augusta, Ga; *Jack A Vennes, MD,* Minneapolis, Minn; *Jerome D Waye, MD,* New York, NY, and The Medical College of Wisconsin Faculty

Approved for 23 credit hours of Category I of AMA and 23 elective hours of AAFP. Fee: $300.

Info: Joseph E Geenen, MD; Walter J Hogan, MD, GI Section, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Phone: 414/291-0813.

UPPER MIDWEST

DECEMBER 10-12, 1980: *Neurology for the Non-Neurologist,* Sheraton Plaza Hotel, Chicago, Ill. Sponsored by Rush-Presbyterian-St Luke's Medical Center. Approved 20 credit hours of Category I of PRA-AMA. Info: Leslie Bryan, CME, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina St, Chicago, Ill 60612. 312/942-7095. 8,10,11/80

FEBRUARY 20-21, 1981 (KANSAS): American College of Physicians Meeting, Downtown Ramada Inn, Topeka. Info: Max S Allen, MD, University of Kansas Medical Center, 39th Street & Rainbow Blvd, Kansas City, KS 66112.

MARCH 2-6, 1981: Seventieth Annual Meeting of the United States-Canadian Division of the International Academy of Pathology, at the Palmer House, Chicago, Illinois. The Maude Abbott Lecture entitled "The Impact on Time on the Diagnosis and Treatment of Cancer: 1936-1981," will be deology," with Dr Robert T McCluskey as course director. The long course will be on "The Inflammatory Process and Infec- livered by Dr Lauren V Ackerman on March 3. Scientific papers, poster sessions, twelve specialty conferences, and 50 short courses are scheduled. A special course will be offered on "Immunopathologic Techniques in Diagnostic Pathtious Disease," with Doctors Guido Majno and Ramzi Cotran, course directors. Further info: Dr Nathan Kaufman, Secretary-Treasurer, United States-Canadian Division of the IAP, 1003 Chafee Avenue, Augusta, Ga 30904; telephone: 404/724-2973. g7-12/80

MARCH 20-21, 1981 (NEBRASKA): American College of Physicians Meeting, Omaha. Info: Bowen E Taylor, MD, Box 81009, Lincoln, NE 68501.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Toll free number 1-800/362-9080.

APRIL 5-9, 1981 (ILLINOIS): American Society of Neuroradiology, Chicago, Ill.

APRIL 6-9, 1981 (MISSOURI): 62nd American College of Physicians Annual Session, Kansas City. Info: Robert H Moser, MD, FACP, Executive Vice President, 4200 Pine St, Philadelphia PA 19104.

APRIL 30-31, 1981 (NORTH DAKOTA): American College of Physicians Meeting, Jamestown. Info: Harold W Evans, MD, 2624 Olson Drive, Grand Forks, ND 58201.

MAY 1-2, 1981 (IOWA): American College of Physicians Meeting, University of Iowa, Iowa City. Info: William B Galbraith, MD, 115 Eighth St NE, Cedar Rapids, IA 52401.

OTHERS

JANUARY 15-17, 1981 (COLORADO): American College of Physicians Meeting, Broadmoor Colorado Springs, Colo. Info: Edward S Miller, MD, 4567 East Ninth Ave, Denver, Colo 80220.

JANUARY 28, 1981 (HAWAII): American College of Physicians Meeting, Hilton Hawaiian Village, Honolulu, Hawaii. Info: James J Ball, MD, 1319 Punahou St, #1190, Honolulu, Hawaii 96826.

FEBRUARY 13-22, 1981 (CRUISE SHIP): *Symposium on Current Concepts in Diabetes and Radiology.* Cruise Ship S S Volendam. Ports of Call—Antigua, St Maarten, St Thomas, Santo Domingo. 48 credit hours Category I of AMA, LCCME Category I. Educational program fee: $400. Info: Ann Bailey, CME, 610 Walnut St, Room 454, Madison, Wis 53706. Phone: 608/263-2854.

FEBRUARY 28-MARCH 8, 1981 (Spain): Pediatric Update—1981. Sponsored by Department of Pediatrics of Long Island Jewish-Hillside Medical Center at Marbella, Spain on the Costa del Sol (Sun Coast) Hotel. Approved for 20 credit hours in Category I of AMA-PRA and 20 credits LCCME. Faculty: Professors Victor Dubowitz, London, England; John O Forfar, Edinburgh, Scotland; Walter H Hitzig, Zurich, Switzerland; Ettore Rossi, Bern, Switzerland; R Zetterstrom, Stockholm, Sweden. Info: Continuing Education Coordinator, Long Island Jewish-Hillside Medical.Center, New Hyde Park, NY 11042. Phone: 212/470-2114. 11/80

Fifth Annual GI Assistants Course Sponsored by Section of Gastroenterology, The Medical College of Wisconsin

"ENDOSCOPIC ACCESSORIES"

February 26, 1981, Pfister Hotel, Milwaukee, Wisconsin

This one day seminar will focus on the wide assortment of equipment developed for use with gastrointestinal endoscopic and procedural examinations. The course is designed to provide a comprehensive, yet practical, overview of the operation, clinical indication and use of GI procedural "tools" used by the gastrointestinal assistant.

Course is being held in conjunction with the 8th Annual Endoscopy Conference for Physicians, sponsored by The Medical College of Wisconsin, February 24-27, 1981.

Registration fee: $125.

Info: Ms Marcia Pfeifer, RN, Course Director, Gastroenterology Consultants, Ltd, 1333 College Ave, Racine, Wisconsin 53403.

MARCH 7-12, 1981 (COLORADO): *National Rural Primary Care Association,* fourth national conference in Denver, Colo. Info: Search Committee, NRPCA, Box 1211, Waterville, Maine 04901; Attn: Vicki Coates.

MARCH 8-15, 1981 (HAWAII): Postgraduate Course in Sports Medicine, Sheraton Hotel, Maui, Hawaii. 25 hours of Category I of AMA-PRA. Course is scheduled to coincide with the Maui Marathon to accommodate those registrants who wish to participate in the race. Info: Marianne Porter, Center for Sports Medicine, 2-063, 303 E Chicago Ave, Chicago, Ill 60611. 10-12/80

APRIL 23-25, 1981: *American Cancer Society National Conference on Human Values and Cancer: Psychological, Social and Ethical Issues.* Washington Hilton Hotel, Washington, DC. 15½ credit hours of Category I of AMA/PRA. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference on Human Values and Cancer, 777 Third Ave, New York, NY 10017. g9tfn/80

MAY 2-22, 1981: *Program in Health Policy, Planning and Regulation,* conducted at the Harvard School of Public Health by an interdisciplinary faculty drawn from the Harvard Graduate Schools of Public Health, Business, Law, Medicine, Government, and Arts & Sciences. Intensive training in management and analytic skills for senior leaders in health delivery and health-related organizations. Info: Assistant Director for Administration, Executive Programs in Health Policy and Management—Dept NR, 677 Huntington Ave, Boston, MA, 02115.

JUNE 21-JULY 31, 1981: *Program for Health Systems Management,* conducted at the Harvard School of Public Health by an interdisciplinary faculty drawn from the Harvard Graduate Schools of Public Health, Business, Law, Medicine, Government, and Arts & Sciences. Focuses on the managerial skills of leadership, resource allocation and institutional policy and strategy required by senior executives in health industry organizations. Info: Assistant Director for Administration, Executive Programs in Health Policy and Management—Dept NR, 677 Huntington Ave, Boston, MA 02115.

AMA—1980

DECEMBER 7-10: Interim AMA House of Delegates, San Francisco Hilton, San Francisco, Calif.

AMA—1981

FEBRUARY 12-15: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9: Interim AMA House of Delegates, Las Vegas Hilton, Las Vegas, Nev.

AMA—1982

FEBRUARY 25-28: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8: Interim AMA House of Delegates, Fountainbleu Hilton, Miami, Fla. ■

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

SUPREME COURT RULES AGAINST LAETRILE USERS. The US Supreme Court ruled October 20 that use of laetrile by terminal cancer victims is not a constitutional right. The justices upheld a federal appeals court ruling that because no such right exists, the government is free to ban the substance. In 1979 the Supreme Court upheld a federal ban on the interstate shipment of laetrile. Left unresolved after the ruling, however, was the question of whether terminal cancer victims have a right, under their right to privacy, to use laetrile. The court's recent ruling left open the possibility for the court to study the issue in depth at some later date.

MEDICAID MEDICAL AUDIT COMMITTEE FORMED. Gerald C Kempthorne, MD, Spring Green, is chairman and Richard W Edwards, MD, Richland Center, is vice-chairman of the newly formed Medicaid Medical Audit Committee which held its first meeting August 27 with state Medicaid officials. The committee supplies technical advice to Medicaid administrators on appropriateness, quality, and quantity of medical services provided for patients under the Medicaid program.

GROUP FORMED TO AID BRAIN-INJURED. When brain injury occurs in young adults whether through accident, illness, tumor, or stroke, a number of special needs are created. Yet up to now Wisconsin has had no central place where information and help could be found. Recently a group of families and friends decided to do something about this. The Wisconsin Brain Trauma Association, Inc was formed as a nonprofit, nonpartisan corporation to provide self-help and specialized programs and facilities for the State's brain-injured population. Dues are $5 annually. Physicians may want to make patients aware of the new group whose address is: 5511 Lynwood Drive, Madison, Wis 53705. Rachel Westbrook is president and she can be reached at 608/233-9554.

OSTEOPATHIC ASSN SETTLES SUIT WITH CHIROPRACTORS. The American Osteopathic Assn (AOA) has agreed to a settlement in the four-year-old antitrust suit filed by five chiropractors against the AOA, American Medical Assn, American Hospital Assn, Joint Commission on Accreditation of Hospitals, and several specialty societies. Under the agreement the AOA is prohibited from interfering with relationships between chiropractors and osteopathic physicians or hospitals, leaving these relationships to individual discretion. The AOA also agreed to pay $30,000 in legal fees. The suit charges that medical and health organizations have conspired to restrain competition. It is scheduled to go to trial November 20 in US District Court in Chicago.

SMALLPOX VACCINATION WAIVERS RECOMMENDED. The World Health Organization (WHO) recently declared the world free of smallpox. Smallpox vaccination of civilians is now indicated only for laboratory workers directly involved with smallpox or closely related viruses such as monkeypox, vaccinia, and others. Since there is no evidence that smallpox vaccine has therapeutic value in the treatment of herpes simplex infection, warts, or any other disease, this vaccine should never be used therapeutically. As of August 15, 1980, only four nations in Asia and Africa—Democratic Kampuchea (Cambodia), Madagascar, Djibouti, and Chad—continue to require an up-to-date certificate of smallpox vaccination as a condition of entry, even though medical reasons for this requirement no longer exist. Since smallpox vaccination carries a small risk of serious complications for the vaccinees and their contacts, WHO provides waiver letters to travelers for whom vaccination is contraindicated for health reasons. Because of the risk associated with this vaccine, the Division of Health continues to recommend giving medical waiver letters, signed by a physician, to all travelers entering these countries. Any suspected smallpox cases should be reported immediately to the Division of Health Immunization Program, 608-266-2346. ■

STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN MEDICAL JOURNAL

DECEMBER 1980

• *Special:* Medical practice in Algeria • *Scientific Medicine:* Gray-scale ultrasonography: The liver and biliary tract in cystic fibrosis • *Organizational.* Council gets PSRO update . . . Society forms ad hoc committee on health practitioners • *Index:* Wisconsin Medical Journal, volume 79, January 1980-December 1980

Vol. 79 #12

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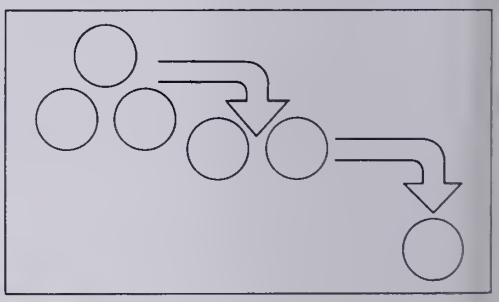
*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



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Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy

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WISCONSIN MEDICAL JOURNAL

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State Medical Society of Wisconsin

THE STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841 . . . Representing nearly 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections, with all members belonging to the American Medical Association. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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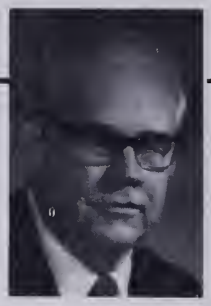

Russell F Lewis, MD

A patient talks

RECENTLY one of my patients gave me a little lecture that I would like to repeat here. She is an intelligent, young housewife with four children, on the birth control pill. She came in for her annual examination, including the Pap test.

She started out by saying, "I suppose you've just read all the reports from the American Cancer Society on the value and benefit of the yearly Pap test;" but then she said, "I want you to listen to my side of the story, and I also want you to do a yearly exam and include a Pap test." She went on to say, "It's my interpretation that what the Cancer Society is saying is that the value obtained for doing routine yearly Pap tests is not worth the cost for the average woman at my age. My interpretation of that is that if they did a million Pap tests on a million women in the course of one year, it would cost many millions of dollars. They would turn up a certain number, and I don't know how many, of early cancers that could be cured relatively inexpensively, and it would require a number of more investigative procedures on some of those Pap tests that were not that clear-cut. In all likelihood, none of those million women would die of cancer of the cervix. It is also possible that some other form of female cancer might be picked up among a group of this size by this test. My interpretation of what they have said is that in contrast to this group, if those same million women my age had a Pap test only every three years, they would obviously save many millions of dollars in office calls, the Pap test itself, and investigative procedures. Out of those many millions they could well afford to treat those few women who get cancer of a more advanced kind, and there really wouldn't be very many of them that would die because the disease wasn't picked up early enough. If there is even one, I don't want it to be me, and I will come and get my test every year because to me, as an individual, the cost benefit, whatever that is, is well worth it."

This lady's analysis of her chance of getting cancer intrigues me, because after a lifetime of dealing with women and their interesting unpredictability, I could add a third thing to something that happens with certainty besides death and taxes. In counseling women about birth control as they approach their 50th birthday, I semi-jokingly and semi-seriously state that at age 50 they no longer need to worry about getting pregnant because the chances are approximately one in four million. Every woman to whom I have made that statement has half jokingly and half seriously said, yes, and that would be me. This lady felt the same way about her chances of getting cancer and not getting adequate protection.

All of us in the practice of medicine, from the time we began, realize that every procedure we carry out has a "cost benefit" factor, and I am totally convinced that the majority of physicians rarely order procedures that they do not feel indicated. They don't prescribe treatment without feeling that the benefits, whether they be cost or medical, outweigh the disadvantages. One of the reasons for the success of large medical school facilities and clinics is that they tend to delve deeper into problem cases with more expensive procedures. A high percentage of these would have been done by the family physician had the patient not started looking elsewhere; and, of course, we all know the advantage of time insofar as obscure signs and symptoms turning into easily diagnostic signs and symptoms.

My entire concern on this whole "cost benefit" philosophy springing up, *eg,* the routine annual examination philosophy, is that of people other than physicians and patients getting into the decision-making process. Obviously the patient is involved in making this decision, but when somebody is sitting in a legislative or government bureaucratic position or an insurance clerk with a cookbook manual at her desk is given authority to make this type of decision, it seems to me that it definitely would be the beginning of the end.

What can we as physicians do about it? I would like to suggest at least two approaches, and I am sure many of you have others:

1. Make sure our patients are educated as to what cost benefits may be and how these affect them as individuals, and what we feel is particularly in the patient's best interest. For example, as an obste-

trician-gynecologist, I am firmly convinced that the majority of my patients, perhaps not all, should have a yearly breast, pelvic, and Pap exam. The patient and I should decide which ones can go longer, not somebody sitting in judgment in Washington or an insurance company's home office.

2. Much has been written and said about cost containment. All of you are familiar, I hope, with the document published in the June BLUE BOOK issue of the *Wisconsin Medical Journal,* outlining those cost containment tips suggested by the Brown County Medical Society. We as physicians should review those and use those suggestions that apply to our particular practice in our day-to-day work. It would seem to me that if we could seriously look at hospital utilization, for example, it might well be possible for us to help the State of Wisconsin in meeting the 4.4% cost reduction with a cutback in fees, and I am totally convinced without jeopardizing quality of care, which is always the main concern of us as physicians. ■

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Editorials

Editorial Director: WAYNE J BOULANGER, MD

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Laetrile "triumph"

HIS SURGEON described the situation couched in scientific terms. "He had cancer all the way to his diaphragm, and cancer from the right lung was pushing into the left lung." The patient was a Hollywood film star who had gone south of the border for treatment of his malignancy.

His treatment included the use of Laetrile, the injection of animal cells, and a plethora of vitamins. This treatment was developed by an unfrocked dentist and has been deemed worthless by the American Cancer Society.

The malignancy, as widely publicized, was a mesothelioma. The surgery according to news releases was performed to remove "a dead tumor." This consisted of the removal of a five-pound tumor from his abdomen and a smaller one from his neck.

Whether or not the tumor was dead might have been a matter of speculation, but certainly there is no question about the late actor himself. So chalk up another "triumph" for Laetrile. —VSF

California, here I come!

PERIODICALLY the California Board of Medical Quality Assurance (equivalent to the Wisconsin Medical Examining Board) issues a bulletin listing disciplinary action taken against physicians.

Here are some examples of situations resulting in revocation of license or periods of probation:

"Gross negligence and incompetence in performing a vasectomy. It took almost four hours and caused extreme injury including transection of the urethra."

"Gross negligence and incompetence in numerous plastic surgery cases. Aided and abetted the unlawful practice of medicine by ordering his nurses to do surgical procedures and by allowing them to prescribe and dispense dangerous drugs, including controlled drugs."

"During the performance of nasal surgery, and while he was mentally ill and under the influence of drugs, respondent sliced the patient's upper lip and placed an instrument into the patient's ear, perforating the eardrum."

There were two cases of "gross negligence in using synthetic fibers for hair implants, resulting in rejection, infection, and scarring to the scalp."

There were two situations of "sexual transgressions by psychiatrists with female patients."

There was another described as "indiscriminant prescribing and furnishing of dangerous drugs to young people for sex favors, and knowing that some drugs would be illegally resold to others."

Another physician falsely represented he could diagnose conditions from Polaroid photos he took of the patients and sent to a lab for analysis. He would then treat the patients with two useless devices.

A most prevalent cause for disciplinary action was "prescribing dangerous drugs without prior examination and without medical indication, and to a person not under his treatment for pathology or condition."

Although there are undoubtedly some medical malefactors in Wisconsin, there seems to be a disproportionate share of quacks and medical weirdos in sunny California—the land of colonic irrigation, advertised in flashing neon signs, chains of dental offices with such names as "Painless Parker," and the soliciting cosmetic surgeons. Small wonder that the rates for professional liability insurance are astronomical in that area.—VSF

2000

ALTHOUGH THERE has been a great deal of concern expressed about the possible glut of physicians in the year 2000, there will be many much more serious situations at the beginning of the twenty-first century. The Department of State, through its Council on Environmental Quality, has projected a warning for global 2000. The conclusion is that "the earth may no longer be able to support life as we know it, unless nations act now."[1] In the year 2000 the world will be more crowded, more polluted, and even less stable ecologically, and more vulnerable to disruption than the world we live in now. Despite greater material output, the world's people will be poorer in many ways than they are today.

Despite efforts in some areas, it is anticipated that in 20 years the number of people on the globe will grow from the 1975 population of 4 billion to 6.35 billion in the year 2000, or more than a 50 percent increase. The rate of growth will slow very

slightly, but in sheer numbers the population will be growing faster in 2000 than it is today with 100 million people added each year. This compares with 75 million in the year 1975. Ninety percent of this growth will occur in the poorest countries.

The economies of the less developed countries are expected to grow at faster rates than those of the industrialized nations but the gross national product per capita in most of these countries will remain low. This is expected to show particularly in Latin America, but in the most populous nations of South Asia it will remain at below $200 per year. It is also expected that the gap between the rich and poor nations will widen even further.

World food production is expected to rise by 90 percent. However, this translates into a global per capita increase of less than 15 percent over the same period. Unfortunately, most of that increase goes to countries that have relatively high per capita food consumption. In some areas like South Asia and the Middle East and Africa the situation will not improve and could actually decline below the already inadequate levels. And even more unfortunately, real price for food is expected to double. Higher yields are anticipated, but most of the elements contributing to this such as fertilizer, pesticides, power for irrigation, and fuel for machinery depend heavily on oil and gas.

The problem of energy will undoubtedly compound itself. The richer industrialized nations will be able to command enough oil and other commercial energy supplies to meet rising demands for another ten years. But because of the expected price increases the less developed nations will have increasing difficulties in meeting energy needs. The need for fuel wood will exceed available supplies by about 25 percent before the turn of the century. Coal, oil, gas, oil shale, tars, and uranium are theoretically sufficient for centuries, but they are unevenly distributed and this will pose difficult economic and environmental problems. Nonfuel mineral resources appear generally sufficient to meet demands through the next 20 years. However, the quarter of the world's population that inhabits industrial countries will continue to absorb three-fourths of the world's mineral production.

By the year 2000 there certainly will be regional water shortages. Population growth alone will double the need for water in nearly half the world. Greater increases would be needed to improve the standards of living. Development of new water supplies certainly will increase in cost and water supplies will become increasingly erratic as a result of extensive deforestation.

The world's forests are now disappearing at the rate of an area half the size of California annually. Most of this is occurring in Africa, Asia, and South America. By 2000, about 40 percent of the remaining forests covering the less developed countries will be gone. Growing stocks of commercial-size timber are projected to decline 50 percent per capita.

Perks and privileges*

WHEN FIRST given this assignment, I had some misgivings. All that seemed to be needed was a listing of the patronizing perks and privileges given the aged and aging in a youth culture with little sense of history and vast inexperience.

I am willing to lay down the humdrum burdens and only ask that I be heard when I speak in defense of the pragmatic virtues of good sense, intellectual honesty, sincerity, simplicity, tolerance and freedom, civility and good humor.

For this I have listed cans and cannots, and the perks and privileges which I have earned.

To quote George Bernard Shaw: "Hell, in short, is a place where you have nothing to do but amuse yourself."

I cannot change my age nor the disabilities incidental thereto.

I cannot change my heritage as a physician.

I cannot change my past with its successes and its errors.

I can change, by living well, the stereotype of aging in a "youth" culture.

I can, with grace and good humor, tact and empathy, turn the hustle and bustle of a busy practice over to younger colleagues.

I can, without fear, and no longer needing favor, resist the depersonalization implicit in the increasing industrialization, mechanization, and fragmentation of the care of the sick.

Oxford American Dictionary defines "perks" as "Perquisites: 'Privileges given or looked upon as one's right.' "

I will exercise the perks I have earned:

1. As a senior colleague, to act as a discerning and friendly critic of society and of the institutions in which I have served.

2. I will continue to act as advocate for all patients and to protect them from fraud and abuse.

3. I will continue to keep myself informed of medical and social trends and be aware of times and places of forums where these subjects may be discussed. ■

***Secretary's note:** These remarks were presented by Herman J Dick, MD, Sheboygan, at the first annual meeting of the Senior Physicians Association of Wisconsin in Madison, October 18, 1980. They speak with remarkable clarity to the place of the older physician in our profession and our society. A report of the meeting appears elsewhere in this issue.—ERT

Farmland will deteriorate due to erosion, loss of organic matter, salinization, alkalinization, and waterlogging. Even now an area of cropland and grassland approximately the size of Maine turns to barren wasteland each year and the spread of desert-like conditions is expected to accelerate.

At the same time environmental conditions will probably deteriorate because of atmospheric concentrations of carbon dioxide and ozone-depleting chemicals which are expected to increase at rates that could alter the world's climate and upper atmosphere dangerously. Acid rain from increased combustion of fossil fuels (especially coal) threatens damage to lakes, soils, and crops. Plant and animal species will become extinct with increasing frequency. Perhaps 20 percent of all species on earth will be irretrievably lost as their habitats vanish, particularly in the tropical forests.

The gloomy conclusion is that these projections for global 2000 may actually underestimate the impending problems. And beyond the year 2000 it looks even worse. At the projected growth rates the world's population would reach 10 billion by 2030 and 30 billion by the end of the twenty-first century. These figures approach scientific estimates as to the maximum carrying capacity of the entire earth. In some areas the carrying capacity has already been exceeded, resulting in poverty and ill health. If this cycle continues, hunger and disease will claim more infants and young children, and more of those surviving will be mentally and physically handicapped by malnutrition.

And just what does all this have to do with the physicians of Wisconsin? In 1980 perhaps there is not too much connection. But looking ahead, the problems of sustaining a decent life for human beings are enormous and getting closer. Perhaps somewhere there may be a real use for all of those excess physicians. Perhaps there is real need for physicians to be more interested than the average citizen in what is happening to our world and to display the caliber of leadership that might be expected from health professionals. —VSF

1. *Agenda,* Agency for International Development, September, 1980. ■

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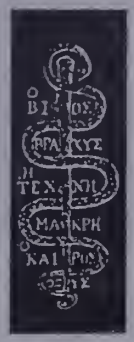

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Thursday, Dec 11: Madison General Hospital. **A Day of Pediatrics.** 9:15 - 5:00. Update on Rhinitis and Asthma, *Marcus Cohen, MD* and *J Brent Kooistra, MD;* Neonatal Resuscitation, *Richard D Zachman, MD;* Strabismus for Poets, Pediatricians & Primary Care Physicians, *Burton J Kushner, MD;* Infantile Diarrhea: New Infectious Agents and Their Outpatient Management, *Thomas N Saari, MD;* Family Therapy and the Hyperactive Child, *Charles J Hodulik, MD;* Scoliosis and Related Spinal Disorders, *John R Whiffen, MD;* Common Pediatric Fractures Encountered in Office and Emergency Practice, *Richard E Calvin, MD*

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* * *

Wednesday, Jan 14: UW Center for Health Sciences. **Adolescent Medicine.** 9:30 - 5:00. The Pregnant Teenager, *Jon K Sternburg, MD; John N Stephenson, MD; Kathryn Kuhnen, RN; Ronald W Olson, MD.* Psychosocial Issues From the Family & Community Perspectives, *Michael Sweetman, PhD; John N Stephenson, MD; David L Weber, MD;* Sexual Abuse, *Patty Warner; Ann Beal; Jeff Patterson, DO; Pat Patterson, MSSW;* Eating Disorders, *Richard B Anderson, MD; Gerald J Bargman, MD; Nancy Hageman, RN;* The Adolescent & Chronic Diseases, *Elaine H Mischler, MD; Gerald J Bargman, MD; Jon K Sternburg, MD; Sara Parrell, RN*

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* * *

Thursday, Feb 19: St Mary's Hospital Medical Center. **Diabetes.** 8:30 - 4:00. The Diabetic—Who, Why & Then What?, *Donald A Daugherty, MD;* Complications of Diabetes, *Richard J. Hendricks, MD;* Diabetic Acidosis: Diabetic Management During Surgery, *Andrew L Kosseff, MD;* Diagnosis of Polyarthritis, *Thomas J Hirsch, MD;* Oral Anti-inflammatory Agents for Arthritis: Current Perspectives, *J Timothy Harrington, MD;* Case Management Problems: Arthritis and Nonarticular Rheumatism: Selected Problems in Family Practice, *J Timothy Harrington, MD* and *Thomas J Hirsch, MD*

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* * *

Wednesday, Mar 11: Methodist Hospital. **Geriatrics: A Young Specialty.** 8:00 - 4:30. Normal Changes of Aging, *Robert J Whitehouse, MD;* Maximizing Function in the Elderly, Geriatric Clinic Staff; Laboratory Testing in the Elderly Patient, *William H Card, MD;* Evaluation of the Demented Patient, *Daniel E Britton, MD* and *Stanley W Boyer, MD;* Sensible Use of Psychotropic Drugs in the Elderly, *David Shraberg, MD (Tulane University);* Roundtable on Neuropsychiatric Problems in Aging, *Doctors Shraberg, Britton & Whitehouse;* Update on Lens Implants/Common Eye Problems in the Elderly, *Richard F Baske, MD;* Panel on Genitourinary Changes and Sexuality in Aging, *Paul A Herzog, MD; John D Wegenke, MD; Robert J Whitehouse, MD;* Special Dental Needs of the Geriatric Patient, *Paul J Dorrell, DDS;* Problems of Mobility in Older Patients, *Harvey L Barash, MD; David J Rolnick, MD; ED Hommel, DPM*

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* * *

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Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

In answer to Dr George Rowe

I FEEL I should respond to the presentation by Dr George Rowe (The HMO—caveat emptor?: *WMJ,* November issue), if for no other reason than to point up what I hope was the major thrust of my editorial (HMOs—A devisive force in medicine?: *WMJ,* September issue); namely, that before physicians get involved with the HMO movement, they should understand it as totally as they can and then make an informed decision as to whether the HMO is for them. My impression is that many physicians are being semicoerced into participating against their better judgment; therefore, if they are armed with more information, they are in a better position to make that decision.

I would like to emphasize again Doctor Rowe's statement that third-party payers "welcome the physician into the HMO arrangement." As was pointed out previously, the HMO arrangement makes the physician an active participant in an insurance program. Doctor Rowe makes the point that since money is involved, the errors created tend to be on the side of saving money, a very logical conclusion. It is my personal feeling that the major objection organized medicine has had throughout the years, and in my opinion still has, to the HMO concept is not that it violates the freedom of choice for physician as much as it does imply somehow that the quality of care will not be as good as it is in the fee-for-service arrangement. Despite many documented reports to the contrary and the total absence of any proof that quality of care is compromised, this still in the minds of most physicians is logically the biggest detriment to the HMO concept. It is a vital issue which must be continually studied. Knowing Doctor Rowe and his intellect and ability as a diagnostician, I would hope that the story which he told to illustrate his philosophy was not misinterpreted by other people as the reason for basically objecting to HMOs; but I would like to contribute my own story.

A little over two years ago a middle-aged female school teacher, participating in the Greater Marshfield Plan, saw her family physician in Wausau for a heart problem. He referred her to an excellent cardiologist in the city of Wausau who did a complete examination, including arteriograms, etc. She was not satisfied with this as time went on and demanded consultation. She was sent to the Marshfield Clinic where she was again seen by a very competent cardiologist who made one mistake. He accepted all of the laboratory and x-ray studies that had been carried out in Wausau, in keeping with the established policy of trying to avoid unnecessary duplication of costs. After review of these studies, plus a careful history and physical exam, he advised the lady as to what he felt was the situation, and she returned home. A little while later she was still unhappy with the two decisions, which were reasonably similar, and demanded from her family physician a third opinion, so she was sent to the University of Wisconsin Hospitals in Madison where all the studies were repeated. The HMO picked up the cost of all three of these examinations, three separate places. The lady returned home, was not happy with the decision made in Madison, which was essentially not too different from the previous opinions, consulted a second internist in Wausau who felt that she was deteriorating and felt it was important to have a reevaluation by an excellent cardiologist. She refused care in either the Wausau or Marshfield areas and subsequently was allowed to go to the Mayo Clinic in Rochester, Minn, where the studies were repeated once again, and once again paid for by the HMO; but a somewhat different impression was given to the lady. However, the records that we have seen, and they certainly are incomplete, would indicate that the diagnosis and treatment were not dissimilar from previous evaluations. The patient at this point, having recently returned from the Mayo Clinic, is very happy; but we anticipate hearing from this individual again. When this happens, I suspect the HMO will put down its foot and say it will not cover any consultative services outside of the area. It has to be my impression, based on quite a bit of experience, that the latter situation is more common that Doctor Rowe's.

This situation is submitted to illustrate what may well be the differences in HMOs. I would believe that the example cited by Doctor Rowe happened in an HMO in which physicians had little or no input in policy decisions. When physicians have active participation, and perhaps even control of an

HMO, my story related above should be more often the case.

While the clinic Doctor Rowe mentioned that doesn't identify the patients so that no one feels there are two classes of care, I suspect it was also done with the understanding that there are many physicians who, if they know the patient does not have to pay for something, will order many more tests than they perhaps might otherwise do, so it becomes a standoff.

The patient, who is the most important aspect of this whole subject, should have an option. The option that exists under the HMO is basically some limitation as to freedom of choice of a physician and location for receiving healthcare benefits versus what, in the past at least, has been a somewhat lower cost. I have to believe this option is a viable one and should be made available to patients, if possible, without compromising quality of care.

Russell F Lewis, MD, President
State Medical Society of Wisconsin

MD Fees in perspective

IT WAS PLEASING to read your timely and provocative editorial "$$ New procedures $$" (*WMJ*, October 1980) pointing out the exhorbitant fees being charged for transluminal angioplasty.

You correctly point out that this is merely the tip of the high fee iceberg. The medical profession should be looking at all physician fee structures and putting them in their right perspective. We have always been advised to avoid discussion of fees because of the threat of price-fixing and I think at times this has been a convenient excuse for not doing so. I believe the whole problem of physician fees has to be examined and fees justified not according to some nebulous and arbitrary scale but, rather, according to the training and skill of the operator and, most importantly, the contribution that procedure makes to the well-being of the patient. As new investigative and therapeutic procedures become more commonplace, require less time and skilled assistance, and have fewer complications, it would seem the cost should be proportionately reduced. I have yet to see this happen.

Each specialty should be examining its fee structure, particularly as regards to some of the routine investigative procedures, and make efforts to reduce the cost of these. Every physician should know the charges of the consultants who perform these procedures. One has only to ask the patient for a copy of his bill in order to become familiar with these charges and then spread it by word of mouth. Responsible Medical Society leaders should be vocal in condemning some of the high fees now being charged. I doubt this would ever be considered price-fixing.

Jeremy R Green, MD
Green Bay, Wisconsin

WMJ's attention to human welfare lauded

I AM A MEMBER of the editorial staff of the *Journal of the Kansas Medical Society*—the context in which I read your *Journal*. I am also a freelance writer—often on topics relating to social issues—and am an active member of the Unitarian Universalist Service Committee, an organization vitally concerned with human welfare; and it is in these contexts that I wish to commend your *Journal* and its policy makers for two items in your current (September) issue.

First is the editorial "Sick in a Strange Land" (pg 9). The refugee population tends to be characterized as an exasperating phenomenon rather than as a group of individual human beings with human emotions and human problems. Your plea for medical support to supply them with adequate health care is most refreshing and encouraging.

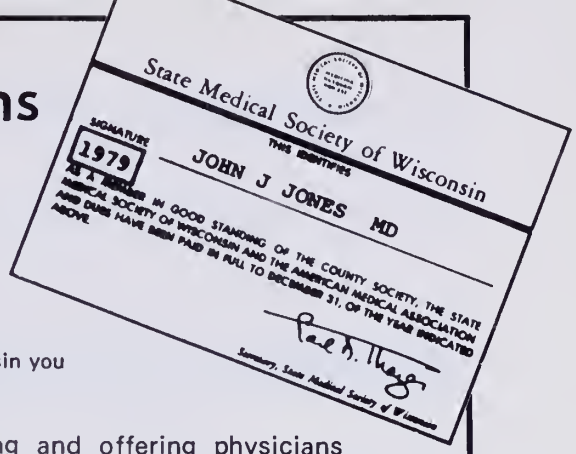
Second is the article, "The Quiet Holocaust," by Karen Middleton (pg 15). Your publication of her excellent article serves to inform your readers not only of the deplorable conditions of which she writes, but also of the level of care, awareness, and intelligence of many of our young people.

Please extend my appreciation to those responsible for the atmosphere in which such attitudes are communicated.

Eleanor Bell
1206 MacVicar
Topeka, Kansas 66604

Editor's note: It is gratifying to receive an occasional compliment such as the one above . . . it helps to reinforce our "labor of love" efforts. We hope Ms Bell sees the editorial "2000" appearing elsewhere in this issue. —VSF■

Why 4,835 physicians carry this card! . . . . .



These are challenging times for any profession —times when you need the active, aggressive support of your national, state, and county medical societies to give you the professional edge you need to advance and grow. As a member of the State Medical Society of Wisconsin you receive many valuable benefits. Among them:

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- **Wisconsin Physicians Planning Network**—Is working to assure physician representation in the health planning process and new health services systems.
- **An Organized Lobbying Effort**—Working in Madison to ensure Wisconsin physicians have a voice in healthcare problems and issues presented to the Wisconsin Legislature.
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- **Mediation and Peer Review**—Physicians, through a special commission, are "policing the profession" by mediating complaints of the public against physicians and where necessary imposing discipline.
- **Impaired Physician Program**—Was recently formed to help the impaired physician—the doctor suffering in some degree from alcoholism, other drug dependency, or mental illness.
- **Member Benefit Plans**—The Society offers comprehensive life, health and liability insurance plans for physicians and their families at attractive group rates. In addition, physicians can receive practice management tips at seminars sponsored by the Society and take advantage of car rental and travel programs at special low, "member" rates.
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- **Community Health**—Society physicians are working with community organizations and individuals in providing consumer health education programs to promote a healthier Wisconsin citizenry.
- **CESF**—The Society's Charitable, Educational and Scientific Foundation, through its physician members, administers a student loan program to help students prepare for careers in healthcare; sponsors postgraduate teaching programs for physicians; owns and operates the Museum of Medical Progress in Prairie du Chien; and for the past two years, has participated in a Jail Health Care Accreditation Program of the American Medical Association.
- **Uniform Claim Form**—These forms, developed by the Society working with local insurance carriers, can be used by physicians in submitting claims to all private insurance companies in Wisconsin, Medicare, and Medicaid.

Special

Medical practice in Algeria

Don E Detmer, MD and **Lewis A Leavitt, MD**
Madison, Wisconsin

THIS PAPER describes a cooperative experiment in international medical education between the University of Algiers and the University of Wisconsin-Madison. Since 1977 multiple visits between faculty of the two schools have occurred. Two Algerian faculty members are currently on the Wisconsin campus pursuing fellowships in surgery and administrative medicine. Early experience suggests that the experiment will succeed only to the extent two conditions are met. The first is the signing of a cultural agreement between the two governments. The second, which is perhaps even more important, is the development of meaningful personal relationships between colleagues of the two universities.

IN 1977 THE University of Algiers in Algeria and the University of Wisconsin-Madison first explored the possibility of developing a special collaborative relationship. Among the initial contacts was a visit to Algeria by a team of Wisconsin faculty; Dr Edwin Wallace has been primarily responsible for maintaining contacts. Madison has been visited by Professor Messaoud Zitouni, Dean of the School of Medicine in Algiers, and five other Algerian faculty members. Two surgeons are currently working here at the University of Wisconsin Hospital and Clinics. Dr Lamine Fahssi came to the Madison campus to spend a few years receiving training in cardiac surgery and Dr Salah Laoubi is pursuing a fellowship experience in peripheral vascular surgery and administrative medicine.

Early in 1979 the authors of this paper went to Algiers for a week to discuss medical administration, primate research, social medicine, health services research, pediatrics, and surgery. This paper summarizes some observations and informs readers about the relationship between the two universities.

Algeria is located on the northern coast of Africa, and its capital city, Algiers, is an ancient port city on the Mediterranean coast. Algiers, with a population of two million, holds approximately one-tenth of the total population of the country. The Casbah, known to most Americans from World War II movies, comprises the oldest section of Algiers and has approximately one-quarter million inhabitants beehived in an area comprising a few square blocks. The country's population is principally located in Algiers, Oran, and Constantine since most of Algeria is comprised of the arid Sahara Desert which is about six hours by car travel south of the coastline. In total land mass, its size is approximately a quarter of that of the United States and is quite important to the United States as a source of energy since Algeria's resources include what are felt to be the largest natural gas deposits in the world. After over a century of French rule, the Algerians in 1962 achieved independence after a bitter, bloody, seven-year struggle that touched nearly all of the families in the country in one way or another. Boumediene, the second leader of the newly independent state, died in early 1979; but the first national four-year development plan, which he began, had become sufficiently established by an educated class of leaders that internal political stability seems assured.

Algeria has a number of problems typical of developing Third World countries. For example, it has one of the highest birth rates in the world and at this point no plan exists to cope with this phenomenon. Over half of the population is under age 20. When one drives through Algiers, one is impressed by the number of children everywhere. Housing and education are major concerns, and the migration of people from the countryside to urban centers, such as Algiers, presents a serious problem to the country's leadership. The social costs of change in traditional rural family relationships brought about by the long war for independence, urban immigration, and industrialization have been significant. Among other indices of this cost are abandoned children, juvenile delinquency, and urban crime. In the current phase of the country's plan of development, healthcare has a high priority and within this area highest priority is being given to increasing the numbers of health professionals, to public health, and to biomedical research.

From the Departments of Preventive Medicine, Surgery, and Pediatrics, University of Wisconsin, Madison, Wisconsin. Reprint requests to: Don E Detmer, MD, University of Wisconsin Hospital and Clinics, 600 Highland Ave, Madison, Wis 53792 (phone: 608/263-4886). Copyright 1980 by the State Medical Society of Wisconsin.

Algeria is a highly socialistic Islamic country. Medical care and drugs are provided "free" to citizens, and in recent years care costs have risen dramatically. Since there are no disincentives for citizens to use primary care services appropriately and the total amount of resources available for medical care is controlled, the availability and development of more sophisticated levels of care have been subsequently affected.

Without a doubt, one of the most delightful aspects of our visit was the pleasure of thawing out in March and avoiding part of one of the worst winters in Wisconsin history. The weather was delightful, the people were most hospitable, and the opportunity to experience another culture was very satisfying. With these comments as introduction, we will describe briefly the educational system and the general healthcare environment.

All children begin school at age six. They have six years of primary education, and then seven years of secondary education divided into four years of middle school and three years of high school. Each year 1,000 students are admitted to the medical school of the University of Algiers. In 1979 there was a total of 6,360 practicing physicians in Algeria of which about one-third were foreigners. Therefore, the physician-to-population ratio is near an astonishing 1:3000. Most of the foreigners are from the Far East, Russia and, to some extent, other eastern European countries. They work by contract with the government and are mostly located in the smaller towns, especially in the south. According to 1979 government statistics, the country has 173 hospitals and 2,500 care centers. There is a serious physician maldistribution problem since most specialists want to live in Algiers, Oran, or Constantine, especially Algiers. In addition to the practicing physicians, there are an additional 1,000 residents in training. Algeria has greatly increased the number of physicians in training and its faculty-student ratio is extremely low. At the University of Algiers there are currently 3,000 medical students. The basic education for physicians is six years. The large number of students and residents has made it difficult for the medical school faculty to experiment much with basic medical research and research in medical education. Nonetheless, we were genuinely impressed with their enthusiasm and progress in some areas.

General surgery in Algeria. The most common surgical problem is biliary tract disease with routine gallbladder surgery and common bile duct procedures occurring at a ratio of approximately 4:1. There are nearly four times more female than male patients, and most of the biliary disease is from cholesterol stones. The second most common problems are ulcers, both duodenal and gastric. Third in frequency are hydatid cysts. Hemorrhoids, anal fistulas, and hernias are then followed by thyroid diseases (goiter, adenoma, and cancer). Carcinoma of the female organs is next and amputations in diabetics round out the common problems. Very rarely they see a parathyroid problem, adrenal problem, or aortic aneurysm. On the thoracic service the most common problems are pulmonary hydatid cysts, tuberculosis, and probably lung cancer but pulmonary carcinoma is not too common. In urology the most common problem is benign prostatic hypertrophy. Patients are very, very reluctant to undergo a colostomy and colon cancer patients generally present with advanced disease.

General pediatrics in Algeria. In keeping with the demography of the country, pediatrics is an important specialty within the University of Algiers clinical services. The practice of pediatrics in Algeria today is heavily involved in the confrontation of infectious diseases, particularly those of early infancy. Preventive and social medicine which have been the keystones of progress in infant and child health care through immunization, sanitation, and infant and family nutrition programs are in Algeria more within the purview of specialists in social medicine than pediatricians. In visiting several of the pediatric inpatient units of the University of Algiers, Mastapha Hospital, Doctor Leavitt was impressed with the skill and knowledge of the pediatric residents. Modern equipment is available for most diagnostic or therapeutic procedures that would be performed in an American hospital but in short supply for the number of patients present.

The pediatrics faculty, many trained in France, read and discuss French textbooks and journals. Although many also read English, American and British pediatric journals are relatively unavailable in the country.

Life as a medical professional. Medicine is considered an important part of the government's practice of socialism. Policies generally come down from above and can have a very profound impact on practice patterns in the country. For example, a few years ago a dictum came down that only surgeons with appointments at University hospitals would be allowed to perform surgery in the region around Algiers. In 1978 another dictum came down that all surgery would be performed solely in University hospitals. In essence this meant that only those hospitals with resident and medical student affiliation programs of the University of Algiers still retained a license to treat surgical patients.

In terms of disposable income, a surgeon in private practice makes more money outside Algiers than most other medical specialists and is quite well paid relative to the educated classes. University faculty receive similar salaries at the same professional level regardless of specialty or academic discipline. Algiers is an expensive city in which to live, especially if one does not own a home or apart-

ment which has been in the family for a number of years. The inflation rate in housing in Algiers makes recent American escalation in home prices anemic by comparison.

It appeared that a number of physicians are married to physicians. The resulting doubling of income gives these couples a substantial amount of economic leverage. The women physicians seem to be mostly in the nonsurgical specialties and very, very few hold directorships of clinical services. Despite this observation, the professional women with whom we spoke felt that they were received as equals at work. In harmony with traditional Moslem teachings, most described a low-profile role outside the hospital and in the home.

Progress between our schools will continue to develop slowly in the coming years. Slowly but surely, contacts seem to be increasing between our two institutions. Until a formal cultural agreement is signed between our two governments, things will almost certainly go more slowly than some of the faculty of both schools would prefer. With continued good fortune, it is hoped that the healthcare and scientific progress of both universities may be fostered.

ACKNOWLEGMENT: The authors acknowledge the helpful comments of Doctors S Laoubi and L Fahssi. ■

NEW PHYSICIANS FOR WISCONSIN . . .

is a physician recruitment and retention project of the Office of Rural Health which has been providing technical assistance regarding health programs to rural Wisconsin communities since 1975.

NEW PHYSICIANS FOR WISCONSIN is partially funded by the State of Wisconsin. Because of this funding no 'front-end' charges are made to clients. A community recruitment committee, a private group of physicians, or a community hospital may enlist the help of NEW PHYSICIANS FOR WISCONSIN without any initial charge.

A fee is required only upon successful recruitment of a physician. Since the NEW PHYSICIANS FOR WISCONSIN program is primarily concerned with the retention of the physician, if the physician leaves before the end of the first year, NEW PHYSICIANS FOR WISCONSIN will recruit another physician at no additional charge. The fee actually covers only a portion of the program's cost which is partially subsidized by the State of Wisconsin.

NEW PHYSICIANS FOR WISCONSIN has a good success record. Its staff has recruited 16 physicians to 12 Wisconsin communities in the 12-month period from August 1979 through July 1980. Eight of the communities are located in federally designated Health Manpower Shortage Areas.

Inquiries to the NEW PHYSICIANS FOR WISCONSIN program have been encouraging. Ads have been placed in national publications and in the *Wisconsin Medical Journal.* Direct mailings have been made to midwestern family practice residencies. The State Medical Society of Wisconsin's Placement Service cooperates in the exchange of information.

NEW PHYSICIANS FOR WISCONSIN frequently helps to develop a community strategy and open discussions concerning the need for additional physicians in the community. Further, it can help communities assess current resources and develop a plan for the addition of new physicians.

NEW PHYSICIANS FOR WISCONSIN maintains a current profile of all recruiting communities. This four-page profile generally reflects the kind of information family practitioners want to know about prospective arrangements. These materials are then sent to physicians along with other appropriate materials supplied by the community.

Communities interested in participating in the NEW PHYSICIANS FOR WISCONSIN program will have access to the physicians who contact the Office of Rural Health, their curricula vitae, and the Physician Information Sheets they fill out for the program.

The Office of Rural Health, in addition to the above program, helps communities write grants designed to increase the number of healthcare providers, build facilities and develop primary healthcare delivery systems. It is very much involved with current health legislation, federal programs, clinic development, and medical education curriculum development.

Administrator of the NEW PHYSICIANS FOR WISCONSIN program is Fred Moskol. Mrs Laurie A Glowac is coordinator. A phone call to either of them (608/263-6690) will provide further information. The Office of Rural Health is located at 777 South Mills Street, Madison, Wis 53715.

NEW PHYSICIANS FOR WISCONSIN is cosponsored by the Wisconsin Hospital Association and the University of Wisconsin Department of Family Medicine and Practice and is advised by a Steering Committee which also includes representatives of the Medical College of Wisconsin, State Medical Society of Wisconsin, and Wisconsin Division of Health. The Steering Committee is chaired by Peter Preussing, who is director of Regional Development at the University of Wisconsin Center for Health Sciences.

★

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Scientific Medicine

REFER TO—Sty JR, Werlin SL, Bruns WT: Gray-scale ultrasonography: The liver and biliary tract in cystic fibrosis. *Wisconsin Med J* 79:23-26 (Dec) 1980

KEY WORDS—Cystic fibrosis, gray-scale ultrasonography, cholelithiasis, liver fibrosis, portal hypertension.

Gray-scale ultrasonography: The liver and biliary tract in cystic fibrosis

John R Sty, MD, Steven L Werlin, MD, and **W Theodore Bruns, MD**
Milwaukee, Wisconsin

ABNORMALITIES of the liver and bilary tract occur frequently in cystic fibrosis patients. We evaluated 91 patients with cystic fibrosis using gray-scale ultrasonography. Fifty-four percent demonstrated abnormal liver parenchymal patterns, 37% abnormal size portal veins and/or increased echogenicity, 36% small gallbladders, and 12% gallstones. Gray-scale ultrasonography proved to be useful in demonstrating common abnormalities of the liver and biliary tract in cystic fibrosis.

LIVER AND biliary tract abnormalities are well known complications in cystic fibrosis (CF). The specific liver parenchymal abnormalities include liver cell atrophy, fatty infiltration, biliary cirrhosis, and periportal fibrosis.[1,2] Often portal hypertension with gastroesophageal varices results from biliary cirrhosis. Small gallbladders and calculi are also common abnormalities of the biliary tract.[3,4,5,6]

Gray-scale ultrasonography has been demonstrated to be an effective diagnostic tool in evaluating diseases of the hepatobiliary tract.[7,8] More recently the technique has been applied to verify abnormalities associated with cystic fibrosis.[9,10] Therefore, we applied this technique to a cohort of patients with cystic fibrosis in order to evaluate both the patients and ultrasound procedure. Our observations are the subject of this report.

From Milwaukee Children's Hospital, Nuclear Medicine Department, Milwaukee, Wisconsin. Publication support provided. Reprint requests to: John R Sty, MD, Director of Imaging, Milwaukee Children's Hospital, 1700 W Wisconsin Ave, PO Box 1997, Milwaukee, WI 53201 (phone: 414/931-1010). Copyright 1980 by the State Medical Society of Wisconsin.

MATERIALS AND METHODS. Ninety-one unselected patients with cystic fibrosis were evaluated with gray-scale ultrasonography. The age of the patients varied from 4 months to 28 years. The mean age was 12 years.

All ultrasound examinations were performed using commercially available gray-scale ultrasound equipment with a 5 MHz or 3.5 MHz transducer. The patients were fasted prior to the study. The liver was scanned in the longitudinal, right subcostal, and transverse planes. The scan technique was produced by varying the overall gain and time-gain compensation. We did not standardize the time-gain because of variability in patient size. The time-gain controls were used to balance the near and far fields of the ultrasound beam. Subsequently the overall gain was increased until spurious echos were noted within the lumen on the inferior vena cava. The overall gain was then decreased to eliminate spurious echos.

The liver parenchyma was evaluated according to echogenicity and beam penetration.[8] The echogenicity of the liver parenchyma was considered abnormal if the echo-density was much greater than the right kidney in the anterior longitudinal scan. Hepatic veins were evaluated according to size. Portal veins were evaluated according to size and echo pattern surrounding them.

The biliary tract was evaluated to detect calculi and measure gallbladder size. If material in the biliary tract produced acoustic shadowing, the material was considered to be calculi. If no acoustic

Figure 1—Anterior longitudinal scan. (1) Microgallbladder. (2) Kidney. The liver parenchymal echo pattern is much greater than the kidney. Note decreased beam penetration.

Figure 2—Anterior longitudinal scan. Arrow marks abnormal increased echo pattern around portal vein.

Figure 3—Right subcostal scan. Arrow marks intrahepatic portal vein with abnormal increased echo pattern.

Table 1—Liver parenchymal echo pattern

AGE (YEARS)	< 10	> 10	TOTAL
Normal	21 (60%)	21 (37.5%)	42 (46%)
Increased	14 (40%)	35 (62.5%)	49 (54%)

Table 2—Portal vein evaluation

AGE (YEARS)	< 10	> 10	TOTAL
Normal	28 (80%)	29 (52%)	57 (63%)
Abnormal size and/or echogenicity	7 (20%)	27 (48%)	34 (37%)

Table 3—Gallbladder evaluation

AGE (YEARS)	< 10	> 10	TOTAL
Normal	23 (66%)	35 (62.5%)	58 (64%)
Small	12 (34%)	21 (37.5%)	33 (36%)
Gallstones	3 (9%)	8 (14%)	11 (12%)
Sludge	3 (9%)	8 (14%)	11 (12%)

shadowing was produced, the material was considered to be "sludge." The gallbladder was measured along its greatest longitudinal axis. If the length was less than 3 cm, the gallbladder was considered small.

All patients had liver function tests (lactic dehydrogenase bilirubin, serum glutamic oxaloacetic transaminase, and alkaline phosphatase) within three months of the ultrasound examination.

RESULTS. Ninety-one ultrasound examinations were performed on children with cystic fibrosis and constitute the basis of our report. In normal patients the liver echo pattern was equal to or only slightly greater than the right kidney when imaged with the anterior longitudinal scan. The patients with liver parenchymal abnormalities such as biliary cirrhosis, fatty liver or hepatitis increased echogenicity and/or decreased beam penetration is noted.[8] Forty-nine patients (54%) demonstrated increased liver parenchymal echogenicity and/or decreased beam penetration (Table 1) (Fig 1).

Liver vascularity was the second parameter that was evaluated. Thirty-four patients (37%) demonstrated increased periportal echogenicity and/or tortuosity of the portal venous system (Table 2) (Figs 2, 3). Evaluating the superior mesenteric or

splenic vein was difficult and no objective criteria for abnormality could be established. The size of the superior mesenteric vein and splenic vein depended on the age of the patient, hydration, or degree of Valsalva maneuver. Hepatic vein enlargement was occasionally noted but could not be correlated with the liver parenchymal echo pattern. Hepatic vein enlargement may be secondary to chronic obstructive lung disease with elevated right heart pressure or secondary to liver disease and associated portal hypertension. No objective criteria for hepatic vein enlargement could be established.

The biliary tract was the third parameter that was evaluated. The gallbladder size was less than 3 cm in 33 fasted patients (36%) (Fig 1). The abnormal gallbladder size did not correlate with the patient's age. Cholelithiasis was present in 11 patients (12%) (Table 3). In one patient biliary calculi were noted in the intrahepatic biliary tract and not in the gallbladder. The youngest child with cholelithiasis was two years. There was an increasing incidence of biliary calculi with the patient's age. Biliary sludge was present in 11 patients (12%). Thirty patients demonstrated a normal liver parenchymal echo pattern, of these 22 had normal liver function tests and 8 had at least one abnormal test. Ten of the 91 patients studied had a serum glutamic oxaloacetic transaminase determination greater than 41 IU. Of these 10 patients all had abnormal liver parenchymal echo patterns.

DISCUSSION. The average lifespan of cystic fibrosis patients has increased during the past two decades because of improved treatment of secondary infections and nutritional deficiencies.[11] Severe lung disease is the most common serious complication of advanced cystic fibrosis. However, liver abnormalities at times may be equally significant. Fatty changes in the liver occur in approximately 30% of all cystic fibrosis patients.[2] Biliary cirrhosis with concretions in the biliary tract are found in 25%. Portal cirrhosis, combined with hypertension and its complications, occurs in 5%. Ultrasonography is useful in detecting abnormal liver parenchymal abnormalities associated with cystic fibrosis, but it will not always distinguish between hepatitis, fatty liver, or fibrosis.

Alternative methods for investigating liver dysfunction in cystic fibrosis include conventional biochemical studies, liver biopsies, or radionuclide 99m technetium sulfur colloid liver scans. The evaluation of hepatic dysfunction in cystic fibrosis using conventional biochemical studies had been shown to have limited clinical value. Serum glutamic oxaloacetic transaminase and serum glutamic pyruvic transaminase determinations may remain normal in as great as 90% of the patients with cystic fibrosis.[4] In addition, cardiac failure or hepatotoxic drugs (*eg,* erythromycin estolate, isoproteronol) can temporarily result in abnormal liver function tests.[12,13] Liver biopsies provide useful information regarding the histology of the liver but are invasive and associated with morbidity and therefore are not recommended in routine follow-up examinations. Radionuclide scanning using technetium 99m sulfur colloid requires intravenous injection of radioactivity, and serial evaluation requires repeated exposures to radiation. In addition, these radionuclide studies give no information regarding the biliary tract.

In cystic fibrosis the gallbladder is often small and may contain calculi.[5] These abnormalities are readily appreciated with gray-scale ultrasonography. This is important because as many as 30% of the patients with cystic fibrosis have nonvisualization of the gallbladder with a double dose oral cholecystogram.[5]

Gray-scale ultrasonography is an ideal diagnostic tool in pediatrics. It is safe, noninvasive, and requires no preparation except for fasting. In cystic fibrosis it will help detect liver parenchymal abnormalities and assist in diagnosing specific abnormalities of the biliary tract. Since there is no radiation exposure, serial examinations are possible without patient risk or discomfort. We found that 12% of our patients had calculi. This compares favorably with the work of L'Heureux, et al[6] who found the incidence of biliary calculi of 11.9% using cholecystography and cholangiography. We also found a 36% incidence of small gallbladders which was similar to the 30% found by Feigelson, et al.[4] In addition, liver parenchymal abnormalities were documented. Feigelson, et al[14] demonstrated that 37% had abnormal radionuclide liver spleen scans. This is similar to our finding of 37% incidence of portal vein abnormality, but less than 54% incidence of abnormal liver parenchymal echo patterns. However, it must be remembered that abnormal liver parenchymal echo patterns are not specific. In addition, although the criteria for liver echogenicity and beam penetration can be used to determine liver parenchymal abnormality, it is subjective.

SUMMARY. Gray-scale ultrasonography confirms the well-known abnormalities of the liver and biliary tract in cystic fibrosis, which have been established by standard radiographic and radionuclide studies, biochemical determination, and liver biopsy. However, it offers advantages in demonstrating the morphologic changes that occur in the hepatobiliary tract. Whether gray-scale ultrasonography will replace many of these more invasive tests will have to be determined from long-range investigation, biopsy, and autopsy material. This was not established with our study.

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Abstracts

Irradiation for inoperable carcinoma of the lung and high performance status

JAMES D COX, MD; RITSUKO KOMAKI, MD; DONALD R EISERT, MD, The Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 244: 1931-1933 (Oct 24/31) 1980

Disagreement continues about the role of immediate irradiation of asymptomatic patients with inoperable lung cancer. Information pertaining specifically to irradiation of asymptomatic patients is scarce. The Medical College of Wisconsin, Milwaukee, reported that survival two years after irradiation was affected by control of the intrathoracic tumor. Ninety-two patients from that study with high performance status (80 to 100 on the Karnofsky scale) were evaluated for long-term survival. Of 54 patients (59%) whose tumors were controlled locally by irradiation, 22% survived five years. None of the 38 patients with uncontrolled thoracic disease lived beyond 27 months. Eight patients are alive and well 53 to 100 months after treatment. No specific late complications of irradiation have been seen. Patients having few symptoms with inoperable bronchial carcinoma can live many years if the tumor is controlled by irradiation. ■

The role of radiation therapy in endometrial cancer

J FRANK WILSON, MD, Department of Radiation Therapy, Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 244:1837-1839 (Oct 17) 1980

Adenocarcinoma of the endometrium has emerged as the most common invasive gynecologic malignancy in the United States demanding continued investigation to optimize available therapy. Continuing efforts to improve and stage results have been successful due to the continuing collaboration between gynecologists and therapeutic radiologists and to more effective use of irradiation. New knowledge has shown tumor grade and depth of uterine wall invasion to be strongly correlated. For example, in the recently reported Memorial Hospital experience only 4% of well differentiated lesions had deep muscle invasion but it was found in 24% of moderately well differentiated and in 48% of undifferentiated lesions. The importance of this is that the incidence of pelvic lymph node involvement sharply increases from 3% when the tumor is confined to the inner third of the myometrium to 36% when the outer third is invaded. Whole pelvic irradiation given preoperatively is potentially the most effective and safest method of eradicating these small foci of disease in cases at high risk of such spread. In the Medical College of Wisconsin experience, external pelvic irradiation to 5400 rad in six weeks by panhysterectomy yielded a five-year, disease-free survival of 80% in patients with Stage II disease. This improvement is largely attributable to the delivery of definitive radiation doses to the parametria and lateral pelvic regions. ■

Adenocarcinoma of the esophagus

ANTONIO BOSCH, MD*; ZENAIDA FRIAS, MPH; and WILLIAM L CALDWELL, MD, Division of Radiation Oncology, University of Wisconsin Center for Health Sciences, Madison, Wis: *Cancer* 43:1557-1561, 1979

The relevant literature is reviewed in an attempt to clarify the true frequency of intraesophageal adenocarcinoma and to evaluate the different treatment modalities and survival of this uncommon type of tumor. The incidence of intraesophageal adenocarcinoma in reported clinical series is about 1%, and data from cancer registries show the incidence to be about 2% for upper and the middle thirds, a more reliable figure than that for the lower third in which lesions of cardia, or stomach infiltrating the lower esophagus have been included. The benefits of any particular treatment modality are difficult to evaluate in view of the rarity of this type of tumor, and the treatment results are as poor as those obtained in the treatment of squamous cell carcinoma.

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REFER TO—Everett HG Jr: Coagulase negative staphylococcal urinary tract infections; a study conducted at five Milwaukee area hospitals. *Wisconsin Med J* 79:27-30 (Dec) 1980

KEY WORDS—Urinary tract infections, *Staphylococcus saprophyticus*

Coagulase negative staphylococcal urinary tract infections

A study conducted at five Milwaukee area hospitals

Harold G Everett, Jr, Milwaukee, Wisconsin

THE PURPOSE of this study was to investigate the significance of urine cultures positive for coagulase negative staphylococci and to determine if *Staphylococcus saprophyticus* exists as a urinary pathogen in the Milwaukee area.

REVIEW OF THE LITERATURE. Pereira in 1962[1] first described a species of coagulase negative staphylococci as a primary pathogen capable of infecting the normal female urinary tract. The organism was originally designated "Micrococcus, subgroup 3," but was later renamed *Staphylococcus saprophyticus* in 1974.[2] The unique characteristic of *Staph. saprophyticus* is its resistance to novobiocin, 1.6 mcg/ml. It appears to cause urinary tract infections almost exclusively in females ages 16 to 50 years. Virtually all females affected are symptomatic, with pyuria and frequently hematuria, as evidence of urinary tract inflammation.

Coagulase negative staphylococci have been found to account for 7 to 30 percent of symptomatic urinary tract infections in Britain and Denmark.[3,4,5,6,7,8] The majority of strains tested were found to be resistant to novobiocin. In a study by Mabeck in Denmark, 23 of 31 patients with coagulase negative staphylococcal bacteriuria were found to have reduced maximal urinary concentrating ability, suggesting acute pyelonephritis.

METHODS. Five Milwaukee area institutions participated in the study: Milwaukee County General Hospital, Veteran's Administration Hospital, St Joseph's Hospital, St Luke's Hospital, and Deaconess Hospital. All clean-catch, midstream urine cultures positive for coagulase negative staphylococci in quantities greater than 10^4 colony forming units/ml were collected during a two-week period, provided that not more than two bacterial species were present in any culture. One colony of coagulase negative staphylococci was then subcultured and tested for novobiocin sensitivity. Basic clinical data were obtained from each patient's records, including urinalysis results and final urine culture colony count. A patient was arbitrarily considered to have pyuria if greater than or equal to 10 white blood cells per high-power field or moderate or many white blood cells were reported on urinalysis, according to the various formats. Greater than 3 red blood cells per high-power field was considered to constitute hematuria.

RESULTS AND DISCUSSION. Fourteen of 18 cultures submitted met the cited criteria. Results are summarized in Table 1.

One culture was found to contain a novobiocin-resistant strain, presumably *Staph. saprophyticus.* This culture was obtained from a 42-year-old female who was markedly symptomatic. She exhibited significant pyuria and hematuria on urinalysis.

Two patients with histories of mechanical urinary tract abnormalities were found to have bacteriuria due to novobiocin sensitive coagulase negative staphylococci. One of these patients was symptomatic, with significant pyuria.

Two immunosuppressed renal transplant patients were noted to have bacteriuria due to novobiocin senstivie coagulase negative staphylococci, one of whom was symptomatic with pyuria.

Of the remaining nine patients only one was known to be symptomatic, while two others exhibited pyuria without symptoms. Five of these nine cultures were positive for two species, indicating possible contamination.

SUMMARY. In summary, it appears that *Staphylococcus saprophyticus* exists as a urinary pathogen in the Milwaukee area. Although it is known that

This study was conducted by the author while a fourth year medical student at the Medical College of Wisconsin, Milwaukee, Wisconsin. The author acknowledges the advice and guidance of Michael W Rytel, MD, Chief, Section of Infectious Diseases, Milwaukee County General Hospital, under whose supervision the study was conducted. As faculty advisor Doctor Rytel has reviewed this paper and supports its publication.
Reprint requests to: Harold G Everett, Jr, MD, 2511 Northrop Ave, Apt 25, Sacramento, Calif 95825 (phone: 916/487-7786).
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Table 1—Summary of data

NO.	HOSPITAL	AGE	SEX	DIAGNOSES	MEDICATIONS
1	VA	79	M	Hemiparesis, arteriosclerotic heart disease, benign prostatic hypertrophy, neurogenic bladder	Bethanechol (Urecholine®), acetylsalicylic acid and magnesium aluminum hydroxide (Ascriptin®), dioctyl calcium sulfosuccinate (Surfak®), quinine, psyllium hydrophilic mucilloid (Metamucil®), propoxyphene napsylate with acetaminophen (Darvocet-N®)
2	Deaconess	50	F	Diabetes mellitus, hypertension	Propranolol hydrochloride (Inderal®), cimetidine (Tagamet®), lente insulin (Lentelletin®), simethicone (Mylanta®), prazosin hydrochloride (Minipress®)
3	St Joseph's	37	F	Partial intestinal obstruction	None
4	St Luke's	60	F	Status/post cerebral vascular accident, hypertension	Hydrochlorothiazide and reserpine (Hydropres-25®)
5	VA	50	M	Parietotemporal hematoma	None
6	Milwaukee County Medical Complex	54	M	Chronic renal failure, renal transplant, coronary artery disease	Digoxin (Lanoxin®), furosemide (Lasix®), nitroglycerin, allopurinal (Zyloprim®), Alu-Cap®, propranolol hydrochloride (Inderal®), folate azathioprine (Imuran®)
7	Milwaukee County Medical Complex	42	F	Raynaud's syndrome, anemia	None
8	St. Luke's	60	M	Arteriosclerotic heart disease, chronic obstructive pulmonary disease, fever	Quinidine (Cardioquin®, Quinaglute®), ethchlorvynol (Placidyl®), tobramycin (Nebcin®)
9	Milwaukee County Medical Complex	29	M	Status/post renal transplant, pancreatitis	Azathioprine (Imuran®), hydrocortisone (Cortef®, Cortril®, Hydrocortone®)
10	Milwaukee County Medical Complex	15	M	Asthma	Anhydrous theophylline (Slo-phyllin®)
11	VA	47	M	Neurogenic bladder	Bethanechol (Urecholin®), dioctyl calcium sulfosuccinate (Surfak®), propoxyphene napsylate with acetaminophen (Darvocet-N®
12	VA	59	M	Pulmonary nodules, adult onset diabetes mellitus, hypertension, status/post cerebral vascular accident, chronic pancreatitis	Quinine sulfate, furosemide (Lasix®), hydralazine (Apresoline®), diphenylhydanto (Dilantin®), methyldopa (Aldomet®), trimethoprim and sulfamethoxazole (Bactrim™)
13	VA	31	M	Inguinal hernia, fever, schizophrenia	Chlorpromazine (Thorazine®)
14	Milwaukee County Medical Complex	44	F	Analgesic nephropathy, chronic pyelonephritis, hypertension	Triamterene and hydrochlorothiazide (Dyazide®), methyldopa (Aldomet®), trimethoprim and sulfamethoxazole (Bactrim™)

URINARY TRACT INSTRU-MENTATION	SYMPTO-MATIC	PYURIA	HEMATURIA	CULTURE RESULTS	NOVOBIOCIN SENSITIVE
No	No	No	No	$>10^4$ coagulase negative staphylococci	Yes
No	Yes	No	No	$>10^4$ coagulase negative staphylococci	Yes
No	No	Yes	No	$2x10^4$ diphtheroids $1.5x10^4$ coagulase negative staphylococci	Yes
No	Yes	No	No	$2.6x10^4$ coagulase negative staphylococci	Yes
Yes	Unknown	No urinalysis on record	No urinalysis on record	$>10^4$ coagulase negative staphylococci	Yes
Yes	No	No	Yes	2 of 3 cultures $>10^5$ coagulase negative staphylococci	Yes
No	Yes	Yes	Yes	$>10^4$ coagulase negative staphylococci	No
No	No	No	No	$2x10^4$ coagulase negative staphylococci, diphtheroids	Yes
No	Yes	Yes	Yes	3 of 3 cultures $>10^5$ coagulase negative staphylococci	Yes
No	No	No	No	$>10^5$ coagulase negative staphylococci	Yes
Yes	Yes	Yes	No	$>10^5$ coagulase negative staphylococci	Yes
No	No	No	No	$>10^4$ coagulase negative staphylococci, rare coliform	Yes
No	No	No	No	$>10^5$ coagulase netative staphylococci, diphtheroids	Yes
No	No	Yes	No	$>10^5$ coagulase negative staphylococci	Yes

Staph. saprophyticus is capable of causing a primary urinary tract infection, it appears that other coagulase negative staphylococci are capable of infecting urinary tracts altered by instrumentation or anatomic defects leading to stasis. Renal transplant patients also may develop coagulase negative staphylococcal urinary tract infections. Therefore, it would appear that the practice of disregarding urine cultures positive for coagulase negative staphylococci is unjustified. Such isolates should be tested for novobiocin sensitivity. If found to be resistant; *ie,* presumably *Staph. saprophyticus,* they should be considered as primary pathogens. Patients from whom these organisms were isolated should then be treated with an antibiotic deemed appropriate on the basis of an antibiogram. Also, therapy should be considered in patients who are symptomatic and from whom a nonsaprophyticus coagulase negative staphylococcus was isolated, provided they fall into the high-risk categories, as identified above.

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Abstracts

Recurrent Cushing's disease: successful treatment by pituitary irradiation or trans-sphenoidal hypophysectomy in two cases

ROBERT H CAPLAN, MD and BYRON L ANNIS, MD, Gundersen Clinic, Ltd, and LaCrosse Lutheran Hospital, LaCrosse, Wis:

Neurosurgery 7:160-165 (Aug) 1980

Two patients developed recurrent Cushing's disease three and seven years after total bilateral adrenalectomy. In the first patient, a 65-year-old man, the adrenal tissue was not localized by radioactive cholesterol scintigraphy. Plain x-ray films of the skull revealed a normal sella turcica. Although clinical improvement resulted from the discontinuation of cortisone replacement therapy, urinary free cortisol levels remained elevated and the patient was treated with pituitary irradiation. Serum and urine cortisol levels gradually returned to normal. Four years after irradiation, the plasma adrenocorticotropic hormone (ACTH) concentration was elevated, but tomography of the sella turcica and urinary cortisol excretion remained normal. The second patient, a 41-year-old man, displayed elevated ACTH levels and x-ray evidence of a pituitary tumor at the time of recurrent Cushing's disease. After trans-sphenoidal hypophysectomy, the hypercortisolism abated and the ACTH concentration returned to normal. Adrenal scintigraphy frequently locates cortisol-secreting tissue in patients with recurrent Cushing's disease, and some investigators suggest treatment by the surgical removal of the adrenal remnant. Although the etiology of Cushing's disease is controversial, current evidence suggests that most cases result from ACTH producing pituitary tumors. The authors suggest that the anterior pituitary gland may be a more suitable target than the adrenal remnant for the treatment of recurrent Cushing's disease. ■

Profundapopliteal collateral index

CLARK H BOREN, MD; JONATHAN B TOWNE, MD; VICTOR M BERNHARD, MD; SERGIO SALLES-CUNHA, PhD, Department of Surgery, The Medical College of Wisconsin, Milwaukee, Wis:

Arch Surg 115:1366-1372 (Nov) 1980

The response to profundaplasty was evaluated in 232 limbs (163 patients) and correlated with segmental pressures and operative flow measurements. Of 150 limbs operated on for rest pain or ischemic necrosis, and inflow procedure (aortofemoral, femorofemoral, etc) combined with profundaplasty was successful in achieving limb salvage in 80 of 96 limbs (83%), but after profundaplasty alone only 26 of 54 limbs (48%) were salvaged. Using segmental pressure measurements, an index of the resistance of the profundapopliteal collateral systems (PPCI) was calculated from the segmental pressure decrease across the knee, and demonstrated an inverse correlation with circulatory improvement. When profundaplasty was performed alone, successful limb salvage was associated with a mean PPCI or .18, compared with .46 in the group with unsatisfactory results. The PPCI is an accurate predictor of the hemodynamic potential of the geniculate collaterals and is useful in the selection of patients for profunda repair. ■

Editor: LUIS B CURET, MD
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REFER TO—Curet LB: Preconceptional control of diabetic women and congenital malformations. *Wisconsin Med J* 79:31 (Dec) 1980

KEY WORDS—Congenital malformations, diabetic pregnancy, perinatology

Preconceptional control of diabetic women and congenital malformations

Luis B Curet, MD, Madison, Wisconsin

RECENT REPORTS indicate that careful metabolic control of diabetes during pregnancy is associated with an excellent perinatal outcome.[1,2,3,4] Such results have been the cause of optimism in the management of diabetic pregnancies. However, in spite of the excellent perinatal survival, a high incidence of congenital malformations continues to be encountered by investigators. In our own series of patients[4] we found an overall 12% incidence of anomalies with a 7% incidence of major anomalies only.

It would appear that strict metabolic control during pregnancy has little if any effect on the incidence of congenital malformations. We have observed that our patients are invariably poorly controlled at the time of their first visit to the High Risk Obstetrics Clinic. In spite of seemingly "good" control as measured by urinary glucose, the two-hour postprandial blood glucose of our patients at the initial clinic visit is usually in the 250-295 mg/dl range. As most of our patients have been initially seen at 12-14 weeks gestation, it appears that during the crucial periconceptional period and first trimester of pregnancy, the quality of metabolic control has been less than desirable. Thus, one can speculate that during the period of organogenesis the metabolic environment for the embryo has been inappropriate and therefore may have predetermined a malformation rate which will remain unaffected by any subsequent strict control.

It has seemed reasonable to assume that if diabetic patients could be better controlled prior to conception, the incidence of congenital malformations could be reduced significantly. With this thought in mind, we have developed a preconceptional diabetic control program at the University of Wisconsin Perinatal Center at Madison General Hospital.

Over the past two years, ten diabetic women who were considering a pregnancy were seen in our clinic and started on a strict protocol aimed at providing an adequate diet with an insulin dose adjusted to maintain the two-hour postprandial plasma glucose under 150 mg/dl.[4] Once adequate control had been maintained for at least one month, the patients were advised to discontinue the use of contraceptives, with pregnancy resulting shortly thereafter. Two of the patients had each had one previous malformed infant. Only one infant born of mothers in this program was severely malformed. This patient, however, had failed to achieve adequate control as desired.

Based on our preliminary observations we strongly recommend that diabetic women of childbearing age should be advised of the desirability of strict metabolic control prior to conception and that an effort be made to monitor blood glucose and glycosilated Hb levels so that an adequate assessment of degree of metabolic control can be made.

From the Department of Gynecology and Obstetrics, University of Wisconsin and the Wisconsin Perinatal Center, Madison General Hospital, Madison, Wisconsin. Publication support provided. Reprint requests to: Luis B Curet, MD, Wisconsin Perinatal Center, Madison General Hospital 7-E, 202 South Park St, Madison, Wis 53715 (phone: 608/267-6099). Copyright 1980 by the State Medical Society of Wisconsin.

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Presented at the Spring Meeting of the Wisconsin Neurological Society, May 9-10, 1980, Madison
Francis M Forster, MD, Madison, Program Chairman

Sudden death, myocarditis, and myasthenia gravis

Robert W Page, MD, Marshfield, Wisconsin

Reports of myocarditis and myasthenia gravis have periodically occurred throughout the literature. The literature from 1901 was reviewed. Most of the cases of myocarditis have been associated with thymomas. The role of the myocarditis has been unknown in the previous literature. A case was presented of an asymptomatic patient with myasthenia gravis. He presented with a superior vena caval syndrome, and treatment with irradiation and cortical steroids was initiated. The patient developed a fulminating course and died an electrocardiographic death. At autopsy coronary arteries were normal and the myocardium demonstrated a diffuse subacute myocarditis. ■

Centronuclear (myotubular) neuromuscular disease presenting in adulthood

David S Dahl, MD, Milwaukee, Wisconsin

A 64-year-old man presented with an eight-year history of slowly progressive leg weakness of subtle onset. He denied craniobulbar weakness and he continued to play the trumpet. His mother and paternal uncle also had mild late-life leg weakness.

He was observed to walk with a Trendelenburg gait and could not walk on heels or toes. There was trace weakness of the biceps brachii and orbicularis oculi. Deep tendon reflexes were hypoactive to absent. He had a lordotic posture and mild contractures of hamstrings and Achilles tendons.

CPK was mildly elevated. Electromyography showed chronic denervation of proximal and distal arm and leg muscles. Also there were fibrillations in lower leg muscles.

Muscle biopsy showed many atrophic fibers with central clear spaces, frequently containing central nuclei; histochemistry demonstrated increased oxidative enzymes in the central areas, Type I atrophy and Type I predominance.

The later onset presentation is rare in an already uncommon condition as only sixty cases are in the world's literature. The histopathologic findings are quite straightforward diagnostically, and are frequently interpreted as indicating neurogenic mechanisms. ■

Safety of anticonvulsants in the hepatic porphyrias

Norman C Reynolds Jr, MD, Milwaukee, Wisconsin

When seizures complicate hepatic porphyria, the precipitation of acute attacks by anticonvulsants is a well known treatment dilemma. The incidence of seizures during an acute attack may be as high as 15% in adults. Porphyria rarely presents before puberty, yet there are cases of idiopathic epilepsy in children who develop acute attacks after receiving anticonvulsant therapy for some time. The list of unsafe agents includes barbiturates, primidone, phenytoin, mephenytoin, ethotoin, ethosuximide, methsuximide, phensuximide, and trimethadione. Reports of safety from short-term clinical trials in patients with latent porphyria are unreliable by comparison with screening procedures using animal systems. With moderately potent inducers such as phenobarbital, numerous cases show exposure from months to years before acute attacks are recognized. Using drug incubation in chick embryo hepatocyte culture, we were able to document significant porphyrin production using carbamazepine, clonazepam, and valproate. These agents should be avoided or used only with extreme caution in suspected porphyric patients. ■

Sudden death, myocarditis and malignant thymoma

Robert W Page, MD, Marshfield, Wisconsin

A 38-year-old patient initially presented with myasthenia gravis in 1972. A clinical diagnosis of myasthenia was made and the patient was started on pyridostigmine bromide (Mestinon®). The patient subsequently discontinued the Mestinon®. When he presented again in the fall of 1978 with a superior vena cava syndrome, he remained asymptomatic from the myasthenia. Chest x-ray films demonstrated a thymic tumor. The tumor was operated and a malignant thymoma was found. The patient was started on steroids and a course of radiation. Shortly after beginning the radiation the patient developed an increase in dyspnea and symptoms of myasthenia. The patient developed intractable cardiac arrhythmias. He died from one cardiac arrhythmia.

On autopsy the coronary arteries were normal but the patient had a diffuse subacute myocarditis. A review of the literature was presented. ■

Cancer Column

Prepared and supported by the Wisconsin Clinical Cancer Center
in collaboration with the State Medical Society of Wisconsin

Immunologic surface markers as prognostic factors for lymphomas and leukemias

A THOROUGH knowledge of prognostic factors of a tumor will help physicians decide if a cautious and conservative or aggressive and persistent course of treating lymphomas and leukemias is best.

Rappaport's pathologic classification of non-Hodgkin's malignant lymphomas is the classification which is generally accepted. However, there is considerable variation between pathologists in the interpretation of lymph node histology.

Factors such as the type of neoplastic cell, degree of cellular differentiation, and pattern of nodal involvement (nodular or diffuse) are important features of prognosis. As a result, a multiparameter approach to make a more definite pathologic evaluation of prognosis and to establish a more rational basis for therapeutic choice is being used. Immunologic surface markers, cytochemical techniques, and ultrastructural studies are often useful techniques.

Immunologic surface marker studies, such as the assessment of T- and B-lymphocyte numbers, often provide significant information in cases of non-Hodgkin's lymphomas. A T-cell acquires its membrane and functional characteristic when precursor cells migrate from the marrow to the thymus where a series of events, such as changes in surface markers and function, occur. This T-cell, or thymus-dependent system, is involved in cellular immunity and can be measured clinically by delayed hypersensitivity skin tests and *in vitro* tests.

The B-cell system (bursal equivalent) functions in antibody production and can be evaluated clincally by measuring serum immunoglobulin levels and antibody response to antigens.

Classifications of lymphomas, such as the Lukes-Collins classification and others like it, take into account that these are neoplasms of the immune system, primarily involving T- or B-cells but rarely histiocytes and monocytes. The cytologic types of lymphoma are similar to normal cell counterparts morphologically and functionally.

They are denoted as undefined, T-cell, B-cell, histiocytic, Hodgkin's disease, and unclassifiable. The undefined classification is used for cellular proliferations with primitive morphologic features that are not distinctive and in which identifying immunologic or cytochemical markers are absent by present techniques. Most of the children with acute lymphocytic leukemia have no surface markers, while the majority of lymphomas are B-cell (68%) and T-cell (20%) in origin.

Editor's note: With discontinuance of supporting funds from the Wisconsin Clinical Cancer Center and services of its science writer, Dorothy J Buchanan-Davidson, PhD, and Paul C Tracy, MD, this is the last *Cancer Column*. The WMJ Editorial Board gratefully acknowledges the support of the WCCC and the outstanding service of Mrs Davidson in coordinating and preparing the columns which started with the March 1976 issue. The Board also acknowledges with thanks the cooperation of the State Medical Society's Committee on Cancer and its chairman, John K Scott, MD.

Cytology alone is not sufficient to adequately evaluate effectiveness of therapeutic agents. Cytologic typing of lymphomas permits recognition of relatively homogeneous proliferations but does not substitute for immunologic markers.

Use of an immune-based classification system for lymphomas permits cytologic types to be consistently identified morphologically, if the histologic material is properly collected and prepared, but there are technical problems in the use of the immunologic surface marker techniques for establishing T- and B-cell cytology. It is especially important to make an accurate diagnosis of T-cell lymphoma, because current chemotherapy schedules, particularly in younger patients, are producing encouraging response and cure rates.

To avoid the need for a second biopsy, minimize the possibility of not obtaining an accurate diagnosis, and hold down costs, a physician must be careful to make suitable biopsy tissue available for

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or the State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1980 by the State Medical Society of Wisconsin.

immunologic marker studies. The critical requirements for initial processing of biopsy specimens are: (1) Specimens [optimal size 1-2 cm x 1-2 cm] must not be immersed in formalin or other fixative but placed directly in sterile tissue culture medium RPMI-1640 in a sterile flask. (2) To enhance cell viability, tissue should be teased apart with two sterile syringe needles [18-22 gauge] to disperse the cells in the culture medium. (3) The samples should not be frozen or stored above room temperature. They may be sent at room temperature to the testing institution. Studies of T- and B-lymphocyte markers usually take about 24 hours to perform.

Doctors N Shahidi, R Hong, and P Sondel of the Pediatric Oncology and Immunology Sections of the Center for Health Sciences in Madison (phone 608/263-6200) will answer questions about immunologic surface markers.

Concepts relating the different morphologic forms of lymphomas to different phases of transformation and maturation of normal B- and T-lymphocytes illustrate a growing awareness by physicians of the nature of neoplastic lymphoid cells, an understanding of the patho-physiology of lymphocyte transformation as expressed in the different morphologic types of lymphoma, and the interrelationship of B- and T-cell lymphomas with lymphoid leukemias.

Dorothy J Buchanan-Davidson, PhD
WCCC, Science Writer ■

Developmental disability—autism, informational materials available

Informational materials on the developmental disability—autism—have been developed by the State Division of Community Services Education/Information Section with funds provided by the Wisconsin Council on Developmental Disabilities. These materials include:

- ***The Puzzle of Autism.*** A brochure describing the syndrome of autism. For general audiences.
- ***Autism.*** A Guide for Parents, Professionals and Others. An expanded version of the brochure with special information for parents, teachers, physicians.
- ***Definition of the Syndrome of Autism.*** This approved definition was developed by the National Society for Autistic Children and is useful for parents and professionals.
- ***Autism Bibliography.*** A listing of books and other materials available on the subject of autism from the Central Wisconsin Center Library Information Center.

Copies of these materials have been distributed to libraries throughout the state. Additional copies may be ordered from the Education/Information Section, Room 561, 1 West Wilson St, Madison, Wis 53702; phone 608/266-0979.

PESTICIDE POISONING TREATMENT MANUAL AVAILABLE. The SMS Committee on Environmental and Occupational Health informs physicians that a pesticide medical treatment manual is available to physicians at no charge from the US Environmental Protection Agency. The 75-page manual, "Recognition and Management of Pesticide Poisonings," devotes a separate chapter to each major chemical classification of pesticides detailing: 1) names of commonly used pesticides belonging to the group; 2) toxicology; 3) frequent signs and symptoms of overexposure, and 4) recommended treatment. To obtain a free copy, physicians must make their request on their professional stationery to: Chief, Pesticide Branch, US Environmental Protection Agency, 230 South Dearborn Street, Chicago, Illinois 60604. ■

"Merry Christmas to ALL..."

Watch the January issue for the 1980-1981 **MEMBERSHIP DIRECTORY** of SMS physicians

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Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Organizational SMS

Council gets PSRO update

Council members were updated on statewide peer review activities at their November 15 meeting by representatives from the Foundation for Medical Care Evaluation of Southeastern Wisconsin (FMCE), and Wisconsin Professional Standards Review Organization (WisPRO). The Society is on record as favoring *all patient* peer review in hospitals.

Appearing on behalf of the Foundation for Medical Care Evaluation was FMCE President Thomas Dehn, MD, Milwaukee, and Executive Director Jerome Coquillard. In his presentation, Doctor Dehn stated that the average length of stay for acute care Title 19 patients in southeastern Wisconsin had dropped from 7 days in 1979 to 6.1 days in 1980.

The Foundation is also currently involved in an areawide (7 counties) quality review study on x-ray retakes. Initial analyses of the study have indicated that hospitals in southeastern Wisconsin have reduced their x-ray retake rate to the level whereby projected savings to the community will be over $1.5 million a year.

In regard to private patient review, Doctor Dehn reported that 650 employers in southeastern Wisconsin are now participating in private review with the Foundation. One of these employers, AO Smith Corp, was recently quoted in the *Wall Street Journal* as saying that their average length of stay had been reduced by almost one full day during the past year of the company's participation in FMCE's program. According to Doctor Dehn, 49% of all licensed physicians in southeastern Wisconsin are currently members of FMCE.

The Wisconsin Professional Standards Review Organization (WisPRO) was represented at the November 15 meeting by WisPRO President John K Scott, MD, Madison, and Executive Director Donald J McIntyre. McIntyre announced that on January 1, 1980, WisPRO received "full designation" from the Federal Dept of Health and Human Services. This now means that WisPRO is fully capable of carrying out all statutory duties of a PSRO in a satisfactory manner, that it will now be funded on a 12-month basis, and that it can only be terminated through formal hearing procedures.

McIntyre reported that during 1980 WisPRO completed areawide quality assurance studies on total hip replacement and congestive heart failure. The total hip replacement study was undertaken in response to a national surgery rate study which showed the hip arthroplasty rate in Wisconsin to be double that of the rest of the nation. However, results of the WisPRO study found that total hip replacements were performed in Wisconsin for appropriate reasons.

The WisPRO area witnessed a total patient days reduction of 17,566 during the one-year period of 1978 to 1979 for a potential savings of $2,687,598, according to McIntyre.

Cameron Brown, executive director of Wisconsin Health Care Review, Inc, appeared before the Council to provide a status report. He stated that SMS, one of several WHCRI sponsoring organizations, has four representatives on the board of directors: John E Dettmann, MD, Green Bay; Darold Treffert, MD, Fond du Lac; John J Satory, MD, LaCrosse (currently WHCRI vice president); and Irwin J Bruhn, MD, Walworth.

WHCRI, which recently was granted nonprofit organization status by the IRS, now employs 30 full-time persons and operates a budget of approximately $1.1 million for three primary programs. These programs include: providing administrative services to the State's EPSDT (early, periodic, screening, diagnosis and treatment) Program; providing nutrition education and health screening to children under the Federal Government's Women's Infants and Children (WIC); and evaluating the effectiveness of the Wisconsin Quality Assurance Project in assuring the reasonableness of cost of nursing home care.

The Council directed the SMS Commission on Public Information to participate in a revision of the "Communications Guide for Wisconsin Hospitals and Physicians" with representatives from the Freedom of Information Council and the Wisconsin Hospital Association. The Public Information Commission is to give a progress report to the Council within the next four months.

Peter Wood of SMS Services, Inc gave a presentation on how SMS Services can "save" the member the cost of membership dues and more through its low-cost insurance programs, auto leasing and rental programs, furniture discount programs, and other benefits. The Council urged all county societies, specialty societies, and hospital medical staffs to invite Peter Wood to their meeting to hear this presentation.

The Council approved the following appointments: To the Commission on Governmental Affairs: Patrick Connerly, MD, Eau Claire (representing the Section on Family Physicians); and John Kreul, MD, Madison (representing the Section on Anesthesiology). To the Physicians Alliance Commission: Richard A Manhart, MD, Cross Plains (anesthesiology). To the Health Planning Commission: Ann Bardeen Henschel, MD, Oconomowoc (anesthesiology). To the Committee on Environmental and Occupational Health: Henry A Anderson III, MD, Chief of Section on Epidemiology, Division of Health. To the Committee on Women Physicians: Lucille Glicklich, MD, Milwaukee, and Pamela Peranek, MD, Menomonee Falls. ■

Physicians call for stricter standards for formaldehyde

The SMS Committee on Environmental and Occupational Health November 5 reiterated its call for stricter standards for formaldehyde vapor exposure in mobile homes. The Committee reaffirmed its position originally taken in November 1979 that the allowable limits for formaldehyde vapor exposure in mobile homes should be set at 0.1 parts per million.

In October the Department of Industry, Labor and Human Relations presented its final proposal, setting the maximum ambient indoor air concentration of formaldehyde at 0.4 parts per million. One year ago, secretary Joseph Noll had indicated that the 0.4 parts per million would be an interim standard, but the current DILHR proposal would make the 0.4 parts per million permanent.

In a news release Committee Chairman WW Schaefer, MD, Sheboygan, stated that DILHR had "ignored and misinterpreted data from investigations conducted by the State Department of Health and Social Services."

The study of complaint cases, conducted by Carl Zenz, MD, West Allis, and Ms Mary Ann Woodbury, RN, conducted between January 1, 1978, and January 25, 1979, found that in 56 homes involving 107 people, the average formaldehyde vapor level was found to be 0.42 parts per million. Individuals involved reported symptoms including eye irritation, cough, sore throat, runny nose, shortness of breath, tightness of chest, headache, fatigue, vomiting, and diarrhea. Six of eleven infants in the affected homes required hospitalization for gastrointestinal problems or respiratory distress. In each of these cases symptoms decreased or stopped when the infant was removed from the house and returned when the infant was brought back to his home. In one of the investigated cases, an infant experienced acute effects from exposure to formaldehyde levels as low as 0.2 parts per million.

"A standard of 0.1 parts per million is a very narrow margin of safety for human dwellings," Doctor Schaefer said. He pointed out that normally, safety factors are set at 10 or 20 times lower than the levels at which some adverse health effects might occur.

"Formaldehyde levels are routinely measured to levels as low as 0.1 parts per million and lower," Doctor Schaefer said. "It is clear to all members of our committee that in the matter of formaldehyde vapors that the health of individuals must receive a higher priority than the potential adverse economic effects that strict formaldehyde standards might have upon the industry." ■

Two Milwaukee physicians to serve on HSA committee

The Milwaukee Medical Community will have strong representation on the Southeastern Wisconsin Health Systems Agency (SEWHSA) new Hospital Services Plan Advisory Committee. Marvin Glicklich, MD, chairman of the Coalition of Medical Organizations (COMO) and Guenther Pohlmann, MD, a MSMC Board member and chairman of the SMS Commission on Health Planning, will take on the 12-to-18 month assignment. The primary task of the HSA committee will be to identify and recommend the closure, consolidation, or conversion of hospital facilities and services in Southeastern Wisconsin. ■

Resolution deadline for annual meeting

The 1981 House of Delegates sessions will be held March 26-28. All resolutions must be submitted in proper form to the Secretary's office at SMS no later than Monday, January 26, 1981 (two months prior to the first session of the House). It is important that county medical societies, specialty sections, and members submit resolutions early to facilitate early distribution of materials and allow all delegates to adequately represent their county medical society or specialty section. If a resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS staff is available to assist in preparation of fiscal notes. ■

Museum Theater named in honor of Doctor Dessloch

More than 60 friends, colleagues, and well-wishers were on hand at the Fort Crawford Medical Museum November 1 to say "thank you" to Eli Max Dessloch, MD of Prairie du Chien.

The main focus of the day was the dedication of the theater in the Stovall Hall of Health as the "Dessloch Theater."

From his home and office practice located just one block away from the museum complex, Doctor Dessloch has made countless contributions to the facility since its creation in 1960. The plaque which will hang in the theater entrance emphasizes this support: ". . . his dedication and contributions to the museum have continued unceasingly . . . he has raised funds, guided tours, replaced pecling paint, mowed the lawn, encouraged local and statewide support, and provided a continuum of principle and practical approaches to the development of the museum." ■

Richard W Edwards, MD, Richland Center (left), chairman of The Aesculapian Society, and Eli M Dessloch, MD, Prairie du Chien. The Aesculapian Society is the medical history arm of the CES Foundation. —*Staff photo by LaVerne Bartel*

Society forms ad hoc committee on health practitioners

As the practice of medicine has changed in complexity and in methods of delivery, so too have the professionals delivering the care. The fact that many nonphysician professionals are seeking to deliver care, or are delivering care, which constitutes in some part the practice of medicine, served as a basis for a resolution adopted by the 1980 House of Delegates.

The resolution directs the Council to review existing laws which deal with the various health professions, including The Medical Practice Act, and to develop an enlightened and progressive policy for physicians and allied health professionals to follow in their shared responsibility in patient care.

The Council has appointed an Ad Hoc Committee on Health Practitioners to propose recommendations and report back to the 1981 House of Delegates.

Committee members are: Doctors Michael Mehr, Marshfield, chairman; Paul Haskins, River Falls; JD Kabler, Madison; Carl Eisenberg, Milwaukee; Allen Tuftee, Beloit; Roger von Heimburg, Green Bay; and Theodore Fox, Antigo. Anyone wishing to provide input to the committee is encouraged to do so. Don Lord of the SMS Physicians Alliance Division will provide staff support. ■

Teachers, students applaud 1980 Work Week

"Rustproofing People—Series II was another super conference. We appreciate your efforts in supporting such an educational program."—A high school teacher referring to the 1980 Work Week of Health

* * *

The teacher in the above quote typified the common response the State Medical Society of Wisconsin and its Auxiliary received from teachers and students alike regarding the 1980 Wisconsin Work Week of Health.

This year's program, which was held at two separate locations—Madison and Stevens Point, focused on the family.

Doctor Robert DuPont, a national authority on marijuana and the former director of the National Institute on Drug Abuse, told the more than 800 teachers and students in attendance that marijuana constituted the single biggest health threat in America today.

Doctor DuPont, a Maryland psychiatrist and current president of the American Council on Marijuana, told the students that they were at a very vulnerable age to start using marijuana, mainly because peer pressure is so strong at this age. As one student told him: "Marijuana is not a drug, it's part of the scene—like blue jeans."

Doctor DuPont warned that contrary to what some people think, marijuana is by no means a harmless drug. "It contains more tar and cancer-causing agents than cigarette smoke and has been found to affect the brain, reproductive system, and other areas of the body," he said.

Complementing Doctor DuPont's remarks were presentations by SMS Council Chairman Darold Treffert, MD, Fond du Lac, and Jack Westman, MD, Madison, on how teenagers can meet the challenge of the 80s. Their talks focused on the issues of self-worth, peer pressure, and communication in the nuclear family and special family situations.

The 1980 Work Week of Health was the eighteenth such program sponsored by the State Medical Society and its Auxiliary. ■

Thayer challenges TV newscast

SMS Secretary Earl Thayer has protested a Channel 15 WMTV-TV (Madison) newscast (an NBC News Service story) which alleged that "more than half the cost of Medicaid and Medicare in this country is the result of abuse and waste."

The allegation was made by a Buffalo, NY, FBI agent using a single case of a podiatrist as an example of how "doctors" cause such abuse.

In a letter to the station manager, the Secretary called the story "grotesquely false" and a gross disservice to the recipients of Medicaid, physicians, and the public which pays the bill.

A request was made that Channel 15 undertake some positive effort to explore the operation of Medicaid and Medicare in Wisconsin, hearing from knowledgeable and authoritative individuals and organizations in the state including SMS. ■

CES FOUNDATION

CONTRIBUTIONS—OCTOBER 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1980.

Unrestricted

Darold A Treffert, MD; SMS Members—*Voluntary Contributions*

Restricted

NMC Projects, Inc—*Student Scholarship Fund*

State Medical Society—*Grant for Wisconsin Work Week of Health*

Memorials

Leland Pomainville, MD—*Retired Physicians (WD Stovall, MD Memorial Account)*

Mrs Robert Burns—*Mrs Carl Witteborg Sr (Brown County Loan Fund)*

Joan Pyre; Mr-Mrs Earl R Thayer—*Robert Carney*

Joan Pyre; Mr-Mrs Earl R Thayer; Mr-Mrs William Wendle; Mr-Mrs Roy T Ragatz; Robert B Murphy; Dr-Mrs EJ Nordby—*John Bell, MD* ■

Senior physicians gather in Madison

"We may be a little weak in the knees and our muscles may have caused us to falter a bit, and we may be a little dim of vision, but for the most part, physicians who have grown old still have the integrity of mind to make contributions only if they are asked and permitted to do so."

These words spoken by Dr Thomas Leonard, Middleton, went right to the heart of the matter Saturday, October 18, when more than 100 retired physicians and their spouses gathered at Society headquarters in Madison for the first annual Retired Physicians Convention.

The purpose of the meeting was to point out the contributions senior physicians could make to medicine and society and to take steps towards establishing an organization to aid senior physicians in these endeavors. There are nearly 1000 senior physicians in Wisconsin.

During the course of the day, the physicians heard presentations on "CME Credits and Medical Licensure" by Dr Howard Correll, Arena; "Perks and Privileges" by Dr Herman Dick, Sheboygan; "Capturing Our Medical Heritage" by Dr H Kent Tenney, Madison; "Helping Our Retired Colleagues" by Dr Paul J Collopy, Milwaukee, and "Drawing on Our Talent Bank" by Dr Victor S Falk, Edgerton.

Harold McCarty, professor emeritus of radio and television education at the University of Wisconsin-Madison, and his wife Ruth McCarty brought some lightheartedness to the day's events in a series of amusing skits they performed on the theme: "Speak Up! I Can't Hear You."

Keynoting the meeting was State Senator Everett V Bidwell, Portage, who celebrated his 81st birthday October 22. Senator Bidwell told the group that it was possible to retire with dignity and still be very useful. "We could use much of the talent in this room in state government," he said.

Dr Herman Dick of Sheboygan encouraged his colleagues to exercise the "perks and privileges" they have earned. "As senior colleagues, act as discerning and friendly critics of society and of the institutions you have served," he said. "Continue to act as an advocate for all patients and to protect them from fraud and abuse, and continue to keep informed of medical and social trends and be aware of times and places of forums where these subjects may be discussed," Doctor Dick advised. His full remarks appear in an adjacent column.

Dr Howard Correll, Arena, warned his colleagues of growing government intervention in areas such as continuing medical education and relicensure. "The main purpose," he said, "of any senior physician organization must be to act as a moral and ethical beacon—warning of the danger, and to then seek reversal of the present trend."

During the business session, conference participants voted to form a "Wisconsin Senior Physicians Association," adopted a platform, and elected the following physicians to serve as officers for the coming year: President—Thomas Leonard, MD, Middleton; President-elect—Norman Clausen, MD, Mazomanie; Secretary-treasurer—Harold Kief, MD, Rhinelander.

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Workshop for Physicians
and their spouses who are
thinking about retiring

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Further info: SMS Services, Inc,
PO Box 1109, Madison, Wis 53701

WISCONSIN SENIOR PHYSICIANS CONVENTION-ATTENDEES
Saturday, October 18, 1980

Edwin C Albright, MD, Madison
Robin N Allin, MD, Madison
George H Anderson, MD, Stevens Point
Henry A Anderson, MD, Madison
Edward A Bachhuber, MD, Mayville
John Berger, MD, Madison
Gordon W Brewer, MD, Racine
Charles R Brillman, MD, Milwaukee
B I Brindley, MD, Madison
Ben H Brunkow, MD, Monroe
Guy M Carlson, MD, Madison
Homer M Carter, MD, Madison
Norman M Clausen, MD, Mazomanie
Paul J Collopy, MD, Milwaukee
Garrett Cooper, MD, Madison
Howard L Correll, MD, Arena
Dowe P Cupery, MD, Markesan
Herman J Dick, MD, Sheboygan
Victor S Falk, MD, Edgerton
John V Flannery, Sr, MD, Wausau
F John Gouze, MD, Marshfield
James Hurley, MD, Brookfield
Adolph M Hutter, Sr, MD, Madison
Harold Kief, MD, Rhinelander
Howard M Klopf, MD, Brookfield
Palmer R Kundert, MD, Madison
Thomas A Leonard, MD, Middleton
Russell F Lewis, MD, Marshfield
Stanley B Marshall, MD, Hollandale
Kilian H Meyer, MD, Richland Center
Clifford A Olson, MD, Baldwin
Ewald H Pawsat, MD, Fond du Lac
Margaret Prouty, MD, Madison
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H Kent Tenney, MD, Madison
Allen H Twyman, MD, Beloit
Walter J Urben, MD, Madison

Ben H Brunkow, MD—Guy M Carlson, MD—Walter J Urben, MD

H Kent Tenney, MD

Senator Everett Bidwell

Thomas A Leonard, MD

Staff photos by Diane Upton

Platform of the Wisconsin Senior Physicians Association

The following are suggested platform items with regard to the purposes and meaning of this organization.

To establish an organization which will overcome some of the abrupt shocking changes which come to many physicians upon the cessation of their active involvement in the affairs of medicine.

To plan and implement ways and means whereby retired physicians can continue to be a part of the advances and progress of medicine.

To encourage institutions such as hospitals, medical schools, research and public health facilities to continue meaningful relationships with those physicians who have served them in the past, but who are now in retirement—to spread the idea that such continued relationships may be meaningful to both the institution and the physicians who have served them.

To stimulate the idea among the members of this organization that interest, learning, and continued participation in the affairs of medicine, even though it may be necessarily somewhat limited, enhances the happiness of the retirement years.

To encourage the membership to exercise their right of freedom of thought and expression in order that the mature judgment which they alone possess, may be influential in those things which continue to affect the advances and progress of medical care, and to overcome some of the inequities which are bound to occur from time to time.

To stimulate the members of this organization to participate in some of the extra curricular cultural aspects of living such as literature, music, hobbies, arts, crafts and perhaps each year at the annual meeting have a demonstration of such achievements.

Without question, the 20th Century has been the most exciting and rewarding with regard to the advances in both diagnostic and therapeutic technologies. No period in medical history has achieved so much which we, the members of this organization, have lived through all—or most of—this amazing Century. We have not only made that history—we are that history. When we are no longer here, many records of that history will go with us. It is, therefore, suggested as a part of this platform that members become seriously involved in using our knowledge and talents in collecting, contributing, assembling and, ultimately, in publishing a comprehensive history of what medicine has been. This should not be allowed to remain unrecorded. Ways and means of implementing this task will be announced in the near future. Some of you will be asked to help in this project.

It is important that this organization remain a part of the State Medical Society. The executive and administrative staffs of the Society have already done much to insure the success of this organization and are willing to continue to help in every possible way. The affairs of the State Medical Society will also become our affairs. This relationship can help in many ways to keep us on the "cutting edge" of medical progress and enable us not only to receive from them but—perhaps—and hopefully—to give something of worth in return.

The success or failure of this organization is going to depend entirely upon what we put into it. Physicians, as I know them, are innovative and creative throughout the many walks of life. These suggested platform items are only a few of the many possibilities which exist. They present a beginning, a beginning which can widen the scope of our desires.

If we implement these items alone, both we and those with whom we associate, will be better off for having done so.

Thomas A Leonard, MD, Chairman, October 18, 1980

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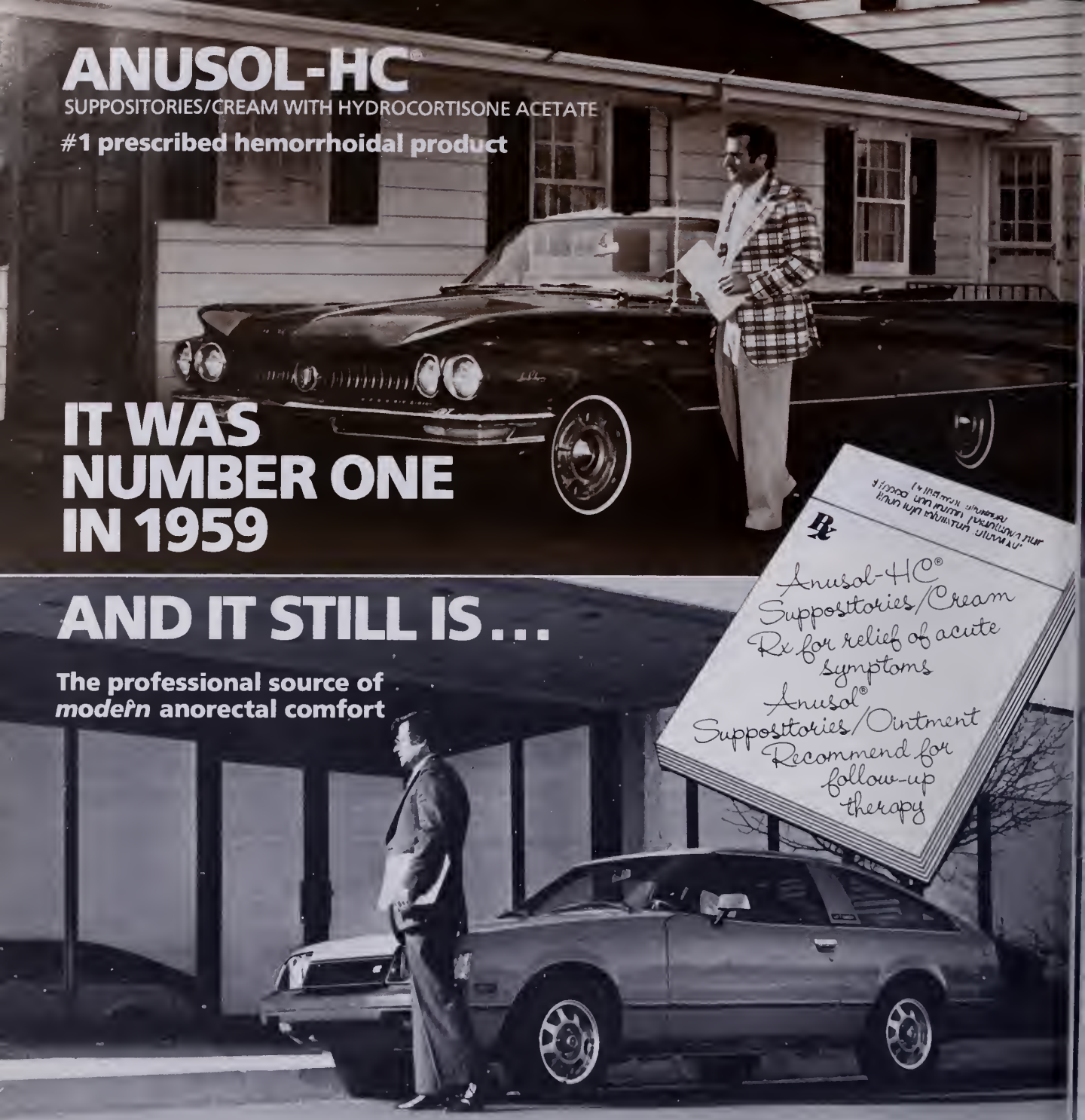

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Hunter forecasts health care under Reagan

The advent of the Reagan administration will mean national health insurance and cost containment proposals will be dead for at least four years, according to the President of the American Medical Association, Robert B Hunter, MD.

Doctor Hunter, speaking at a news conference prior to his address to physicians at the SMS Medical Leadership Conference November 14 in Milwaukee, also said that he expects federal financial support for medical schools will decline under the Reagan administration and that this could put 13 US medical schools in financial jeopardy and even force them to close their doors.

Asked by a *Milwaukee Journal* reporter if the AMA would take a direct effort to prevent a decline in financial support, Doctor Hunter said that the AMA's role is only to inspect and accredit medical schools and that class size determinations are up to the individual schools or with the state if a public school.

More than 100 physicians attended the one-day leadership meeting to hear presentations on physician competition, the political outlook for 1981, specialty society-federation communication, rights and responsibilities of medical staffs, and the county-state-AMA relationship. ■

SMS annuity unit value $3.68

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $3.68 as of October 31, 1980. This compares with $3.57 as of September 30 and $3.46 at August 29. ■

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of October 20, 1980

NEW MEMBERS
County Medical Society

ASHLAND-BAYFIELD-IRON

McCue, John P, 206 Sixth Ave, West, Ashland 54806 (1949, Regular, Family Physician)

BARRON-WASHBURN-BURNETT

Rholl, Mark Allen, 435 South Fifth St, Barron 54812 (1951, Regular, Family Physician)

BROWN

McGuan, Austin R, 1334 Kellogg St, Green Bay 54303 (1946, Regular, Anesthesiology)

O'Reilly, Michael D, 1551 Dousman St, Green Bay 54303 (1950, Regular, Orthopedic Surgery)

Stankevych, Anatol John, 923 Eliza, Green Bay 54301 (1947, Regular, Ophthalmology)

DANE

Anderson III, Henry A, PO Box 309, 1 W Wilson, Madison 53701 (1945, Regular, General Preventive Medicine/Occupational Medicine, Certified-GPM)

Cindy Louise Barron, 5 Dunraven Court, Madison 53705 (1953, Resident, Obstetrics and Gynecology)

Brown, Michael Wayne, 600 Highland Ave, Madison 53792 (1953, Resident, Internal Medicine)

Finch, William W, 1 South Park St, Madison 53715 (1946, Regular, Otorhinolaryngology, Certified)

Hinkeraker, Paul H, 30 South Henry St, Madison 53703 (1949, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)

Laravuso, Raymond B, 600 Highland Ave, B6/387, Madison 53792 (1944, Regular, Anesthesiology, Certified)

Ramirez, Lincoln F, Dept of Neurosurgery, 600 Highland Ave, Madison 53792 (1939, Regular, Neurological Surgery)

Rietz, Daniel R, Dept of Otolaryngology, 600 Highland Ave, F4/2, Madison 53792 (1954, Resident, Otorhinolaryngology)

Russell, Timothy P, 304 North Bristol St, Sun Prairie 53590 (1951, Affiliate, Family Physician)

Songsiridej, Vance, 600 Highland Ave, Madison 53792 (1949, Resident, Internal Medicine/Allergy)

Strohm, John M, 6315 Century Ave, Apt 5, Middleton 53562 (1953, Resident, Anesthesiology)

Weffenstette, Bruce E, Dept of Psychiatry, 600 Highland Ave, Madison 53792 (1951, Resident, Psychiatry)

Weiner, Michael A, 5520 Medical Circle, Ste A, Madison 53711 (1948, Regular, Plastic Surgery)

DOUGLAS

Maryland, Daniel L, 1504 Bel Knap, Superior 54880 (1934, Regular, Ophthalmology, Certified)

GREEN

McCauley Jr, Charles S, 2709 Sixth St, Monroe 53566 (1950, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)

Pollock, James C, 1515 Tenth St, Monroe 53566 (1949, Regular, Internal Medicine, Certified)

JEFFERSON

Clar, Alberto C, 125 Hospital Dr, Watertown 53094 (1944, Regular, Anesthesiology)

Kapustka, Edward S, 426 McMillien St, Fort Atkinson 53538 (1941, Regular, Urology, Certified)

Peterson, Stanley E, 1216 Furseth Rd, Stoughton 53589 (1949, Regular, Orthopedic Surgery/Hand Surgery)

LINCOLN

Carroll, James L, 216 North Seventh St, Tomahawk 54487 (1946, Regular, Family Physician)

Kirchhoffer, James B, 216 North Seventh St, Tomahawk 54487 (1951, Regular, Internal Medicine, Certified)

Valcarcel, Jorge A, 716 East Second St, Merrill 54452 (1947, Regular, Internal Medicine/Oncology, Certified-IM)

MANITOWOC

Momtaz, Ken R, 601 Reed Ave, Manitowoc 54220 (1935, Regular, Family Physician)

ONEIDA-VILAS

Foltz, Richard N, 56 South Brown, Rhinelander 54501 (1949, Regular, Orthopedic Surgery)

Grieco, Joseph Thomas, Dept of Anesthesiology, 44 Kabel Ave, Rhinelander 54501 (1942, Regular, Anesthesiology)

OUTAGAMIE

Mich, Gerald R, 1523 South Madison St, Appleton 54911 (1950, Regular, Family Physician)

Schelble, Thomas C, 401 North Oneida St, Appleton 54911 (1951, Regular, Family Physician)
Smith, Claudius Gregory, 401 North Oneida St, Appleton 54911 (1951, Regular, Obstetrics and Gynecology)
Stanis, George Robert, 401 North Oneida St, Appleton 54911 (1949, Regular, General Surgery)

ROCK

Choung, Steven S, 2657 Austin Place, Beloit 53511 (1946, Regular, Anesthesiology)
Durkee, Paul F, PO Box 629, Janesville 53545 (1926, Regular, Internal Medicine)
Traudt, William Simmons, 2020 East Milwaukee, Janesville 53545 (1949, Regular, Orthopedic Surgery)

WAUKESHA

Ballman, Robert J, 888 Thackeray Trail, Oconomowoc 53066 (1944, Regular, Internal Medicine)
Chambers, Paul R, 123 Lawn St, Hartland 53029 (1951, Regular, Family Physician)

WINNEBAGO

Barton, Michael, PO Box 3063, Oshkosh 54903 (1919, Regular, General Surgery, Certified)

WOOD

Flachsbart, Keith D, 1000 North Oak Ave, Marshfield 54449 (1945, Regular, General Surgery/Thoracic Surgery, Certified-GS)
Heck, Louis J, 1000 North Oak Ave, Marshfield 54449 (1952, Resident, Pediatrics)
Kelman, Donald B, 1000 North Oak Ave, Marshfield 54449 (1942, Regular, Neurological Surgery)
Maloney, Patrick M, 1000 North Oak Ave, Marshfield 54449 (1948, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)
O'Connor, James J, 1000 North Oak Ave, Marshfield 54449 (1949, Regular, Orthopedic Surgery)
Reinhart, Richard A, 1000 North Oak Ave, Marshfield 54449 (1945, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)
Washington, William L, 1000 North Oak Ave, Marshfield 54449 (1946, Regular, Internal Medicine/Rheumatology, Certified-IM)

CHANGE OF ADDRESS
(Does not include those within a city)

BARRON-WASHBURN-BURNETT

Jirsa, Harold O, Cumberland, to 3409 Nottingham Rd, Ocean Springs, MS 39564

DANE

Benson Jr, Ralph C, Madison, to Mayo Clinic, Rochester, MN 55901
Renner, John H, Madison, to 101 Memorial Dr, Kansas City, MO 64108

MILWAUKEE

Fueredi, Adam, Cedarburg, to 53 High Point Cir West, Naples, FL 33940
Masukawa, Teruo, Milwaukee, to 237 Bethesda Ave, Cincinnati, OH 45267

WINNEBAGO

Hinchen, James E, Oshkosh, to 1153 West Lafayette, Jacksonville, IL 62650

COUNTY-TO-COUNTY TRANSFER

Eau Claire-Dunn-Pepin to Kenosha: Koch, Edgar L, 6308 Eighth Ave, Kenosha 53140
Milwaukee to Kenosha: Devan, Douglas G, 7700 Cooper Rd, Kenosha 53142
Milwaukee to Waupaca: Fuhrmann, Donn D, 1420 Algoma St, New London 54961
Oconto to Waupaca: Glazier, Edward H, PO Box 144, Waupaca 54981
Waukesha to Brown: Aldrich, Peri L, 407 South St Augustine, Pulaski 54162
Waukesha to Price-Taylor: Lofland, Leo J, Rte 2, Box 257, Stetsonville 54480
Wood to Price-Taylor: Frederick, T Bayard, 789 S Seventh Ave, Park Falls 54552

DEATHS

Pechous, Charles E, Kenosha County, Sept 13, 1980
Bell, John M, Marinette-Florence County, Oct 1, 1980 ■

Obituaries

☐ County, State, AMA Members

☐ **Charles H Behnke, MD,** 70, Oshkosh, died Aug 2, 1980 in Oshkosh. Born Dec 20, 1901 in Oshkosh, Doctor Behnke graduated from Marquette University School of Medicine in 1934 and served his internship and residency at Milwaukee County General Hospital. A fellowship in ophthalmology-otolaryngology was taken at the University of Pennsylvania Graduate School of Medicine. Doctor Behnke served in the United States Army Medical Corps from 1941 until 1946, during which he was awarded the Bronze Star of Citation. He served as chief-of-staff at Mercy Medical Center and also was president of the Winnebago County Medical Society. Surviving are his widow, Dorothy, and a son, Charles.

☐ **Ernest G Ovitz, MD,** 94, Laona, died Sept 11, 1980 in Green Bay. Born Oct 7, 1885 in Mineral Point, Doctor Ovitz graduated from Northwestern University Medical School in 1912. His internship was served at Wesley Memorial Hospital in Chicago, Ill. Doctor Ovitz had his medical practice in Forest County for 32 years and retired in 1946 because of ill health. Surviving are his widow, Annabel; two daughters, Mrs Gerald (Jean) Scott, Spread Eagle; Mrs Dewaine (Marilyn) Wall of Bellevue, Wash; and a son, Ernest G Ovitz Jr, of Sarasota, Fla.

Joseph G Edwards, MD, 80, Milwaukee, died Oct 24, 1980 in Milwaukee. Born Oct 15, 1900, Doctor Edwards graduated from Marquette University School of Medicine in 1928. He served his internship at St Joseph's Hospital in Milwaukee. Surviving is his widow, Olga.

☐ **Harold W Carey, MD,** 78, Lancaster physician since 1936, died Nov 6, 1980 in Lancaster. Born Nov 4, 1902 in Argyle, Doctor Carey graduated from Loyola University School of Medicine, Chicago, in 1930 and served his internship and residency at Mercy Hospital and Lewis Memorial Maternity Hospital in Chicago. He served as chief-of-staff of Lancaster Memorial Hospital, city health officer, and team physician for the high school athletic department for many years. Doctor Carey also was active in the affairs of the State Medical Society of Wisconsin serving as vice-speaker of the House of Delegates, 1961-1964; councilor of the 4th district, 1965-1970; member of the Committee on Cancer, 1947-1950, and chairman of the Division on Public Assistance. Doctor Carey also had served as president and secretary of Grant County Medical Society.

Surviving are two sons, Dennis Carey, DDS, Madison; Terry Carey, San Diego, Calif; two daughters, Mrs Sheila Dixon, Evanston, Ill, and Mrs. Gerald (Cathleen) Kardas of Albuquerque, New Mexico. ■

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for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

ibrax

ase consult complete prescribing informa-n, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective, as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation

ntraindications: Glaucoma, prostatic hyperhy, benign bladder neck obstruction, hypersitivity to chlordiazepoxide HCl and/or nium Bromide

rnings: Caution patients about possible comed effects with alcohol and other CNS ressants, and against hazardous occupations uiring complete mental alertness (*e.g.*, operatmachinery, driving). Physical and psychologidependence rarely reported on recommended es, but use caution in administering Librium® ordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

[illegible] alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

[illegible] on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings precautions, and adverse reactions.

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(clonidine HCl)
Hypertension

The Alpha Advantage:

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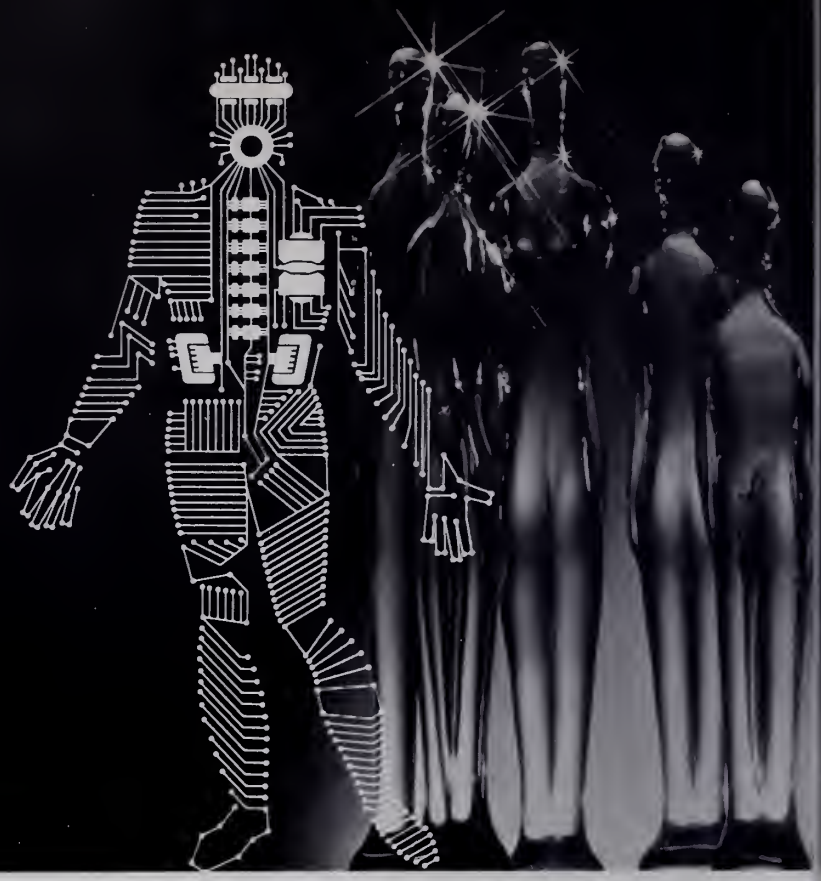
Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mo[illegible] longer.

Adverse Reactions: The most common reactions are dry mouth, drowsine[illegible] sedation. Constipation, dizziness, headache, and fatigue have been re[illegible] Generally these effects tend to diminish with continued therapy. The fo[illegible] reactions have been associated with the drug, some of them rarely. (Ir[illegible] instances an exact causal relationship has not been established.) These i[illegible] Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnorma[illegible] liver function tests; one report of possible drug-induced hepatitis without [illegible] and hyperbilirubinemia in a patient receiving clonidine hydrochloride, [illegible] thalidone and papaverine hydrochloride. Weight gain, transient elevation c[illegible] glucose, or serum creatine phosphokinase: congestive heart failure, Ray[illegible] phenomenon; vivid dreams or nightmares, insomnia, other behavioral ch[illegible] nervousness, restlessness, anxiety and mental depression. Also ras[illegible] gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not ass[illegible] with a rash, impotence, urinary retention, increased sensitivity to alcohol, d[illegible] itching or burning of the eyes, dryness of the nasal mucosa, pallor, gyneco[illegible] weakly positive Coombs' test, asymptomatic electrocardiographic abnor[illegible] manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminishe[illegible] sent reflexes and vomiting followed the accidental ingestion of Catapres (cl[illegible] hydrochloride) by several children from 19 months to 5 years of age. [illegible] lavage and administration of an analeptic and vasopressor led to comp[illegible] covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30[illegible] intervals usually abolishes all effects of Catapres, (clonidine hydrochlorid[illegible] dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as [illegible] (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 10[illegible] available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.
For complete details, please see full prescribing information.
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County Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Washington CMS, legislators discuss physician reimbursement

The Washington County Medical Society invited area legislators to hear a presentation by Dr Thomas Dehn, Physicians Alliance commissioner from Milwaukee, on the Physician Reimbursement Report recently prepared by the State Dept of Health and Social Services.

Legislators present at the meeting were Scott McCallum, R-Fond du Lac; Mary Panzer, R-Mayville; and John Merkt, R-Mequon.

The Legislature earlier this year directed DHSS to prepare a report outlining several options available to it to alter the physician reimbursement system under the Wisconsin Medical Assistance Program (WMAP) (*Medicaid*).

At the present time the WMAP pays physicians according to the individual physician's "profile" of charges to *Medicare.* The five options proposed by DHSS range from a statewide fee schedule for physician services regardless of specialty or geographic location, to various composites of specialty, location, and/or range of charges.

The SMS Physicians Alliance commissioners and staff are currently discussing the physician reimbursement paper at county medical society meetings around the state in order to hear physicians' views on the subject before taking a position on any of the options.

The Legislature is expected to take up the report in January.

Editorial commends MSMC for peer review action

The Medical Society of Milwaukee County received high praise from a local television station last month for its recent inquiry to the State Medical Examining Board as to why it had not "summarily" suspended the licenses of three local physicians who had been convicted of felonies related to medical practice. A WITI-TV editorial stated in part: "*So often a medical society is accused of protecting doctors—not in this case. The Medical Society deserves public commendation for insisting that these doctors be removed from professional practice. The State Medical Examining Board deserves public criticism for not acting promptly on the Society's request.*"

A spokesman for the Medical Examining Board has pointed out that in order for the Board to "summarily" suspend a license, the law requires that it must have proof that the physicians are *continuing* to practice in a manner that is a threat to public health. However, the Board may and has now begun due process procedures which may result in the revocation of the three licenses.

OUTAGAMIE: Dr Charles Sigmund, head of gastroenterology at St Louis University School of Medicine, was guest speaker at the October 16 meeting of the Outagamie County Medical Society at which 31 members were present. His subject was "Diagnosis and current management of inflammatory bowel disease." During its business meeting the Society extended an honorary membership to Guy M Carlson, MD* in recognition of his long and faithful service to the Society. Doctor Carlson practiced internal medicine in Appleton for 57 years before retiring to Madison.

ADAMS-COLUMBIA-MARQUETTE: At a recent meeting of the Tri-County Medical Society the following physicians were elected to offices. They are MDs Thomas E Henney,* Portage, president; Ramakrishnan Sankaran,* Friendship, president-elect; Fredrick H Bronsin,* Portage, secretary-treasurer; Robert T Cooney,* Portage, delegate to the State Medical Society of Wisconsin, and Martin L Janssen,* Friendship, alternate delegate to the Society. ■

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Richard J Boxer, MD,* Fox Point urologist, recently finished a series of lectures in the People's Republic of China, The Philippines, and Hong Kong. He is the author of numerous research papers stemming from work done at the University of California, Los Angeles Medical Center and in Milwaukee. In 1979 he won the American Urological Association's national award for bladder and cancer research.

Matthew Paul Grade, MD, recently opened his medical practice at the Black Earth Clinic. The Clinic is a satellite of the Sauk-Prairie Clinic and Doctor Grade is the full-time physician. He graduated from Northwestern University School of Medicine and completed his residency at University Hospitals in Madison. Doctor Grade also trained in high-risk obstetrics at Maricopa County Hospital in Phoenix, Ariz.

Douglas A Schipitsch, MD, recently became associated with the Cumberland Medical Clinic. Doctor Schipitsch graduated from Loyola University School of Medicine and completed a general surgery residency at St Francis Hospital and at Loyola University Medical Center in Maywood, Ill. He also is a member of the medical staff at Cumberland Memorial Hospital.

Otto V Pawlisch, MD,* John J Rouse, MD,* and **Ernest Stadel, MD,*** Reedsburg physicians, recently were honored by the community. The three physicians have practiced in the area for 155 collective years and received gifts from the Reedsburg Memorial Hospital Auxiliary.

Kok-Peng Yu, MD, Madison, recently began his medical practice at the DeForest Area Medical Clinic. A pediatrician, Doctor Yu graduated from Syracuse University School of Medicine, New York, and completed his internship and residency in pediatrics at the University of Wisconsin Hospital in Madison.

Steve Osicka, MD,* former Amherst physician, has accepted a position with the Waupun Correctional Institution in Waupun. Doctor Osicka is the first full-time resident physician in the history of the institution. He most recently practiced in Berlin and Redgranite.

Stanley B Marshall, MD,* Hollandale, has announced that Robert W Long, MD has resigned from the Hollandale Clinic to accept a position in Cuba City. Cathryn Kaiser, MD, who has been practicing in the Madison area, will begin practice at the Clinic later this year.

W Bruce Fye, MD,* Marshfield, recently was elected a fellow of the Council on Clinical Cardiology of the American Heart Association. A member of the Marshfield Clinic medical staff, Doctor Fye is the director of the Clinic's cardiographics laboratory. He graduated from Johns Hopkins University School of Medicine where he also completed a cardiology fellowship. He joined the Marshfield Clinic in 1978.

Charles J Picard, MD,* Superior, recently was presented a plaque by the Superior-Douglas County Community Blood Bank for his 25 years of service as medical director. John O Simenstad, MD,* Osceola, was the guest speaker at the 25th Anniversary Dinner of the Blood Bank and his topic was "The Forgotten Solution to Health Care Cost." Also speaking was Doctor Picard who presented a historical background of the Blood Bank.

Susan Behrens, MD, Beloit, recently became associated with the Beloit Clinic. Doctor Behrens graduated from the University of Wisconsin Medical School, Madison, and served her internship and residency at LaCrosse Lutheran Hospital and Gundersen Clinic, LaCrosse. In 1978 she received the first place award in the Wisconsin Surgical Society Annual Resident competition. She completed a fellowship in colon and rectal surgery at Ferguson-Droste-Ferguson Clinic and Hospital at Grand Rapids, Mich. Doctor Behrens was the first woman to be trained at this clinic and is one of three women surgeons practicing colon and rectal surgery in the United States.

Robert M Railey, MD, Lancaster, recently became associated with the Grant Community Clinic. A family physician, Doctor Railey graduated from the University of Kansas School of Medicine in 1973 and completed his residency in Cedar Rapids, Iowa. Prior to joining the Clinic, Doctor Railey was associated with a group practice clinic in Cresco, Iowa, for four years.

Reuben Eisenstein, MD, Fox Point, recently was named chief of the Ida Soref-David and Ruth Coleman Department of Pathology and Laboratory Medicine at Mount Sinai Medical Center, Milwaukee. Doctor Eisenstein is a graduate of Louisiana State University School of Medicine and prior to joining the medical staff of Mount Sinai, he was director of Laboratories at Veterans Administration Lakeside Medical Center in Chicago.

Paul S Muenzner, MD, Superior, recently became associated with the Superior Memorial Hospital. Doctor Muenzner graduated from the University of Kentucky College of Medicine and completed his internship and residency at Akron General Medical Center, Akron, Ohio. Prior to joining the medical staff at Superior Memorial Hospital, Doctor Muenzner was associated with the Akron Clinic and also taught in the orthopedic residency programs.

James F King, MD, Wauwatosa, recently assumed the office of president of the Wisconsin Division of the American Heart Association. George G Griese, MD,* Marshfield, was elected president-elect.

Leon Radant, MD, Mauston, recently became associated with the Hess Memorial Hospital medical staff. Doctor Radant graduated from the University of Wisconsin Medical School, Madison, and completed his residency with the University of Wisconsin Department of Family Practice. As a fourth year medical student, Doctor Radant worked in Puerto Cabesas, Nicaragua, and also served in a primary care clinic in a rural area of Southern Alabama.

Robert E Jordan, MD,* dermatologist at the Veterans Administration Hospital, Wood, was named to develop the American College of Physicians sixth Medical Knowledge Self-Assessment Program (MKSAP). The MKSAP concept, developed by the American College of Physicians in the 1960s and now in its fifth edition, was the first comprehensive self-evaluation program designed to help practicing doctors review current medical thought and update their medical knowledge. Doctor Jordan was one of the participants who voluntarily tested his medical knowledge and compared his score with like-minded colleagues.

David Sovine, MD,* Shorewood, recently spoke on "An Overview of Biofeedback" during a medical conference held at Milwaukee Psychiatric Hospital. Doctor Sovine is an assistant clinical professor in the Department of Psychiatry and Mental Health Sciences at the Medical College of Wisconsin, Milwaukee.

Specialty Societies

*PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Wisconsin Society of Anesthesiologists recently nominated the following physicians to represent its specialty in State Medical Society affairs: To the Section on Anesthesiology, Warren J Holtey, MD,* Marshfield, delegate, and James J Brill, MD,* Madison, alternate delegate. To the Physicians Alliance Commission, Richard A Manhart, MD,* Cross Plains, Section representative. To the Health Planning Commission, Ann Bardeen Henschel, MD,* Oconomowoc, Section representative. To the Governmental Affairs Commission, John F Kreul, MD,* Madison, Section representative. Current president of the Wisconsin Society of Anesthesiologists is John J Vondrell, MD,* Brookfield; and W Stuart Sykes, BM, Madison, is secretary-treasurer.

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Wisconsin Radiological Society at a recent meeting elected the following officers for the year 1980-1981. They are MDs Dayton H Hinke,* Marshfield, president; Timothy T Flaherty,* Neenah, president-elect; Daniel J Price,* Milwaukee, vice-president; Mary Ellen Peters,* Madison, secretary-treasurer; Loren Hart,* Green Bay, delegate to the State Medical Society, and Bruce Kirkham,* Eau Claire, alternate delegate to the Society.

Wisconsin Society of Pathologists recently held election of officers in which Charles P Nichols, MD,* of La Crosse was named president-elect. He will take over the presidency in October 1981. Roland C Brown, MD,* of Wauwatosa is the current president. Doctor Nichols had served as the Society's secretary for five years. Succeeding him as secretary is Gerald A Hanson, MD,* of Brookfield. ■

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Southeast Wisconsin Family Practice Center, housed on the first floor of the University of Wisconsin-Parkside's Tallent Hall, recently opened its doors, according to a recent announcement in the *Racine Journal-Times.* Operated jointly by the Medical College of Wisconsin and St Catherine's Hospital, Kenosha, the center intends to alleviate the general practitioner shortage in western Racine and Kenosha counties. The center has no provisions for hospitalization, so adult patients requiring special care will be admitted to St Catherine's. Children will be hospitalized in Kenosha Memorial Hospital's pediatrics department. Currently Ralph Burnett, MD,* director of the family practice residency program and an associate professor in family practice at the Medical College of Wisconsin, has moved his private practice into the center. In July 1981 four residents will come to the center to begin training in family medicine, said Ernest P Celebre, vice president of general administration and development at St Catherine's. Each year after that, another four residents will be added, until by 1982-83, the center will be staffed by 12 residents. Residents selected to participate in the program will be selected from applicants from any accredited medical school. Besides the residents, a program director, assistant director, two practicing physicians, registered nurses, technicians, and office personnel will operate in the center. The center is not a free or a walk-in clinic and all patients must have an appointment, Mr. Celebre stressed.

American Heart Association has named Peter Hanson, MD of Madison as Wisconsin chairman of its exercise and cardiac rehabilitation committee. The committee promotes development of cardiac rehabilitation programs throughout the state and provides information and consultation for existing programs. Doctor Hanson is director of cardiac rehabilitation at the University of Wisconsin Hospital and Clinics. ■

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A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® CIV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g , alcoholics former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, Pa. 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed

WHY NOT WYGESIC® CIV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity: jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

Rheumatologist wanted to join four orthopedic surgeons in a very desirable north central Wisconsin community with a drawing population of 70,000. Active practice assured, shared "on call" provided, research grants available. New Clinic facility located within new 35 million dollar hospital complex. Outstanding personal benefit programs, generous guaranteed income. For further information contact: Lloyd Engstrom at 715/842-3202, or write PO Box 1646, Wausau, Wis 54401. 8-12/80

Family Practitioner wanted: 13-man, mixed group practice seeking family practitioner to join its Family Practice Department of six family practitioners located 100 miles south of the Twin Cities in a community of 25,000. Ideal community with excellent schools and multiple recreational opportunities, new hospital. Liberal benefits and top salary offered. This is a choice practice opportunity in rural southern Minnesota. Please contact James Burns, MD, 210 N St Mary St, Albert Lea, Minn 56007. Phone: 507/373-1441. 10-12/80

Medical Emergency Service Associates (MESA), SC, has an immediate opening for a full-time emergency physician at a hospital in Rockford, Ill. MESA offers a computed salary up to $85,000 annually, excellent working conditions, flexible scheduling and fringe benefits plus the opportunity to join a stable growing corporation dedicated to providing quality emergency medical services. MESA will also consider negotiating relocation expenses. Send your CV or phone MESA, 15 South McHenry Rd, Suite 2, Buffalo Grove, Ill 60090; Mrs Barten (312/459-7300) MESA would like to be a part of your future. 11-12/80

Family Practitioner wanted to locate in an expanding family practice satellite associated with a large multispecialty clinic in east central Wisconsin. Guaranteed salary plus liberal incentive benefits, profit sharing, and many other advantages of a large incorporated medical group. For more information please send resume and CV to M V Mutzelburg, Manager, Fond du Lac Clinic, SC, 80 Sheboygan Street, Fond du Lac, Wisconsin 54935. 11-12/80*

Fifty-physician multispecialty clinic in West Central Wisconsin wants allergist, cardiologist (noninvasive), pediatrician, and family practitioner to do acute medicine. Also family practice openings in nearby satellite offices. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Admin, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5266. 9-12/80

Dermatologist desires partnership, group association or solo location in Wisconsin or Minnesota. Board certified. Experienced surgery, PUVA and x-ray therapy. Contact Dept 485 in care of the Journal. p11-12/80,1/81

The Nicolet Clinic, SC, a young progressive 33 physician multispecialty group, has superb opportunities available for the practice of:

- Nephrology
- Ophthalmology
- Family Practice
- Radiology

Ideal family oriented community in metropolitan area with excellent schools, economy, culture, and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued medical education. Contact in confidence Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Phone: 414/727-4244. 11-12/80,1-2/81

Wisconsin locum tenens available. Family practice, can do OB and ER. High productivity. Write: Locum Tenens, 5695 Merry Lane, Excelsior, Minn 55331. Phone: 612/474-4372. p11-12/80,1-2/81

Emergency Physician. Wausau, Wisconsin. Residency training and/or ER experience required. Fee for service corporation with excellent income and benefits. New facility with excellent backup. Family and sportsman's paradise. Send CV or call: Fred A Klemm, MD, 2404 Hawthorne Lane, Wausau, Wis 54401. Phone: 715/842-9373. p11-12/80,1/81

50-physician multispecialty clinic in west central Wisconsin wants allergist, cardiologist (non-invasive), pediatrician, neonatologist, orthopedic surgeon, otolaryngologist, family practitioner to do acute medicine, and family practitioner for nearby satellite office. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or call 715/839-5266. 12/80, 1-3/81

OBSTETRICIANS-GYNECOLOGISTS WANTED

Obstetricians-Gynecologists board certified or eligible wanted to join in practice with obstetrician-gynecologist in a city of 100,000 on Lake Michigan between Milwaukee and Chicago. Excellent schools, medical school affiliation, security of freedom of practice in independent small group. Contact: Elizabeth A Steffen, MD, 734 Lake Ave, Racine, Wis 53404. Phone: 414/637-8311. 6tfn/80

Physicians Exchange

continued

Medical Director for established staff model HMO in south central Wisconsin. Federally qualified primary care clinic with highly qualified specialist consultants. Board certified family practitioner or internist preferred. Experience or training in medical administration and strong leadership qualities required. Competitive salary and benefit program including excellent pension, insurances, CME, etc. All replies confidential. Write to Patrick Brady, Executive Director, Group Health Cooperative of South Central Wisconsin, One South Park St, Madison, Wis 53715 or call 608/251-4156 for appointment. 11-12/80

Relocation opportunities or initial practice in Fox Valley for general internists, family practitioners, and pediatricians. Support of other independent practitioners assured. Excellent schools, recreational area, as well as clinical facilities in JCAH approved hospital. PO Box 801, Neenah, Wis 54956. p11-12/80,1-4/81

Family Practice. General Clinic — Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Family Practitioner/General Practitioner to join a 50-physician multispecialty group with a 10-man Family Practice Department. Main responsibilities would be to provide coverage at satellite offices within 25 miles of main clinic on a rotation basis. No night calls. Obstetrics and hospital patients optional. Guaranteed salary and excellent fringe benefits. A real opportunity for a qualified physician who is interested in reducing his work load. Contact R L Gilbert, MD, 815 S 10th St, LaCrosse, Wis 54601. Tel: 608/782-9760, ext 129. 12/80, 1-2/81

Grow with us in sunny Arizona. The INA Healthplan needs physicians in family practice and most specialties in Tucson and Phoenix. Competitive salaries and comprehensive benefits including a professional development program, retirement plan, and group incentive bonus are provided. If team interaction and casual living interest you, send your CV to: Professional Relations, INA Healthplan, Inc, 6115 North 7th St, Phoenix, AZ 85014. 12/80, 1-2/81

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Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

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Licensed Employment Agency 9tfn/79

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 20-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 7tfn/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Two-three Board eligible/certified family physician's needed in Northeastern rural Wisconsin. New clinic adjacent to fine 60-bed hospital. Financial assistance available and negotiable. Excellent location, community atmosphere and economy. Contact J Schumacher, Admin, Calumet Memorial Hospital, Chilton, Wis 53014. Phone: 414/849-2386. 10-12/80

Indiana—Fort Wayne: Emergency physician needed. Experience and ability to meet board credential requirements desirable. Unique organization, multiple hospital group owned by all the physicians. Profits returned to physicians, not to entrepreneur. Contact American Medical Services Association, Inc, 4400 Broadway, Suite 306, Kansas City, Missouri 64111, 816/931-3040. 10-12/80

Green Bay, Wisconsin. St Vincent's Hospital expanding emergency group has one opening for career-oriented emergency physician. Flexible work schedule. $90,000 with liberal fringe and educational benefits. Send CVs to Ray Schofield, MD, RR #2, Gillette, Wis 54124. 12/80,1/81

General Surgeon and Orthopedic Surgeon. Both needed for 7-man multispecialty group in town of 10,000. Located 30 miles southwest of Milwaukee. Our facility is immediately adjacent to a 140-bed hospital. Position open immediately. Please contact Wayne Hansen, Burlington Medical Center Ltd, 190 Gardner Ave, Burlington, Wis 53105. 414/763-9121. p12/80,1/81

Family physician or primary care oriented internist to join three-man group. Top salary guaranteed, plus percent of gross first year. Attractive fringe benefits. 350-bed hospital. No personal investment. Contact Donald H McDonald, MD, 510 South First Ave, Winneconne, Wis 54986. p12/80

Family Practice. Wanted a family practitioner to locate in new clinic building in Poynette, Wis. Located 30 miles from Madison, Wis. Poynette is a village of approximately 1000 with a service area of 7000 persons. Salary guaranteed. Contact John Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 10tfn/80

Racine Medical Clinic, SC, multispecialty group of 20 physicians has a practice association for:

- General Surgeon

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 9tfn/80

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Hematology/Oncology
- Otolaryngology

Beautiful new building adajacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

OB-GYN to do gynecology and high-risk OB to join 12 physician primary care practice in northwestern Wisconsin. New 75-bed hospital and new clinic, 100 miles from the Twin Cities. Lester A Thompson, MD, 1020 Lakeshore Dr, Rice Lake, Wis 54868. 10-12/80

Physician wanted to perform light physicals five days per week in the Milwaukee area. Ideal job for retiring physician. Contact Mike Stough, collect, at 513/621-8728. 11tfn/80

Immediate opening for general and child psychiatrist to join well established clinic in a community of 50,000. Large referral area. Two excellent hospitals. University and industrial area. Salary open. Excellent benefits. Contact: J M Tobin, MD, Northwest Psychiatric Clinic, Box 224, Eau Claire, Wis 54701. Phone: 715/834-2751. 12/80, 1-2/81

Thinking of retiring? Medical directorships available, across the USA, any age physician, no fee, malpractice insurance paid, 35 hrs/wk, $35 to 40,000/yr, depending on location. List valid licenses, when able to relocate. Where? Please send resumeq including telephone number to: Fred V Hrachovina, DO, 1000 Second Ave, South, Minneapolis, Minn 55403. 12/80

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095
8-12/80,1-7/81

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

Cardiologist or internist with an interest in cardiology for Twin Cities Internists Group. CCU, EKG lab, and resident teaching responsibilities. Cath lab available. Position requires necessity to deliver some general medical care. Curriculum vitae and references mailed to Dept 486 in care of the Journal. 12/80, 1-2/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multi-specialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Full Time Faculty Position—Assistant Director of the sixth and newest Family Practice Residency Program of The Medical College of Wisconsin. Potential to become associate director, dependent upon qualifications. Faculty appointment to the highly successful Department of Family Practice of The Medical College of Wisconsin. Opportunity to participate in the formulation of a new program; residents to begin training July, 1981. Outstanding Family Practice Center facilities. Candidate must be Board certified or Board eligible in Family Practice. Located in Southeastern corner of Wisconsin; 45 minutes from Milwaukee; 60 minutes from Chicago. Faculty rank and salary are negotiable, dependent upon qualifications and experience. Many fringe benefits. Send curriculum vitae and references to: R G Burnett, MD, Program Director, Southeast Family Practice Residency Program of the Medical College of Wisconsin, Tallent Hall, University of Wisconsin-Parkside, PO Box 598, Kenosha, Wis 53141. The Medical College of Wisconsin is an Equal Opportunity/Affirmative Action Employer. 12/80;1/81

Wanted. Board certified or eligible oncologist to practice in conjunction with an 8-member medical department in a 22-member multispecialty group. Present sub-specialties: gastroenterology and cardiology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Real Estate

Vail Condo—two bedrooms, kitchen, living room, fireplace, beautiful view. $525.00/week. Ralph N Bloch, MD, 9950 West 80th Ave, Arvada, CO 80005. Phone: 303/425-0961 or 303/399-9076. p12/80

CONSULTANT FOR FLORIDA REAL ESTATE

A retired member of the State Medical Society of Wisconsin
HOWARD V. MORTER, MD
Licensed Broker/Salesman
336 GOLFVIEW ROAD #318
NORTH PALM BEACH, FL 33408
305/622-7006
REALTOR-Associate, Duane C. Heiser Realty Co.

Medical Facilities

Office space available in southeastern Wisconsin near 200-bed hospital. Fully equipped, suitable for a Family Practitioner. Metropolitan Milwaukee area. Contact Dept 484 in care of the Journal, or phone 414/965-2200. 10tfn/80

Equipment for sale: Burdick diathermy machine excellent condition. Remington Rand and Cole File card cabinets. Steelmaster double drawer build-up 4x6 card file cabinets. Best offer accepted. Contact: Wilkinson Clinic, Oconomowoc, Wis 53066. Phone: 414/567-4433, ext 267. 11-12/80

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For lease: Approximately 1500 sq ft, furnished or unfurnished, in West Milwaukee, edge of Wauwatosa. 9300 West Capitol Dr, Milwaukee. Perfect for Internist or Family Practitioner. Four exam rooms; consultation, lab, insurance, and waiting rooms. Favorable terms. For further information contact: Phone 414/463-6650. 9tfn/80

For Sale: Zeiss Photomicroscope with circular rotating and centering mechanical stage, automatic exposure device and full power pack. Several objective and ocular lenses. Excellent condition. Regularly maintained by manufacturer's representative. Contact Mr. Bernard Goldstein, 606 West Wisconsin Ave, Milwaukee, Wis 53203. Phone: 414/271-1400. g10tfn/80

FOR RENT office space Greater Milwaukee area. 750-1500 sq ft in prestigious 3-year-old medical building located on Northridge Lakes (7400 West Brown Deer Road) only minutes from Northridge. Opportunity for medical group, specialist, or satellite office. Will remodel to suit. Please call area code 414/354-1160. 12tfn/80

Allied Health Services

Position wanted. Family Nurse Practitioner. 29 year-old male, masters prepared practitioner seeks opportunity to establish jointpractice with innovative Family Physician (s) or General Internist (s). Varied nursing experience and presently employed as an adult nurse practitioner. Interested in triage, care of routine illness, health maintenance, and health promotion. Please address replies to Nurse Practitioner, 10729 S Union Rd, Newton, Wis 53063. 12/80

Advertisers

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Madison Business Systems 22
Medical Protective Company 21
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Librax®
Smith Kline & French Company 35
Dyazide®
Wisconsin Army National Guard 53
Wyeth Laboratories 65, 66
Equagesic®
Wygesic® ■

Publications

Physician Recruitment and the Hospital, by Harry E Olson Jr, PhD, contains practical information on how to set up a physician recruitment program, with special emphasis on the needs of the small or rural community. The roles of the administration, the board, the medical staff, the recruitment committee, and the community itself are discussed.

Published by the American Hospital Association, this book provides step-by-step guidelines for physician recruitment, from assessing the needs of the community to locating potential candidates to retaining the recruited physician.

Doctor Olson is executive director of Health Planning Continuum, Excelsior, Minn, a private consulting firm that assists hospitals and communities in the review of comprehensive medical delivery services and the assessment of need for additional physicians. He was formerly assistant vice-president and corporate director, Community and Professional Relations, Lutheran Hospitals and Homes Society of America, Fargo, ND.

This book should be of particular interest to hospital administrators, board members, physicians, and community leaders, and others who are concerned with maintaining and improving high-quality medical care in their area.

Physician Recruitment and the Hospital, AHA catalog no. 1035, is available for $12 to members and $15 to nonmembers from the American Hospital Association, PO Box 96003, Chicago, IL 60690.

The Alcohol, Drug Abuse and Mental Health National Data Book. A reference book of national data on the incidence of drug and alcohol abuse, practitioners, treatment facilities and services, costs and financing. DHHS pub. no. (ADM) 80-938. Alcohol, Drug Abuse and Mental Health Administration, 5600 Fishers Lane, Rockville, Md 20857.

Marijuana Research Findings: 1980, by Robert C Peterson, PhD. National Institute on Drug Abuse research monograph 31. DHHS pub. no. (ADM) 80-1001. NIDA Division of Research, 5600 Fishers Lane, Rockville, Md 20857.

Biography on Smoking and Health, 1979, compiled by the World Health Organization collaborating center for reference on smoking and health. Technical Information Center, Office on Smoking and Health, Park Building, 5600 Fishers Lane, Rockville, Md 20857.

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

JANUARY 2-3, 9-10, 16-17, 1981: *Third Annual Winterum,* University of Wisconsin Medical School, Administrative Medicine Program, 1981 Winter Weekend Studies.

✔ *Management of Medical Education Institutions*—Management practices for medical education institutions, presented in a seminar format. Planning, policy, budgeting, managerial accounting and control, organizational goals, and future changes. Provides students with an analytical framework pertaining to external pressures for cost containment, uses of accounting information for purposes of external financial reporting and internal decision making, and involvement in the institutional budgetary process. Don E Detmer, MD, and Mark Covaleski, PhD, instructors. Class will meet on Fridays from 6:30-9:30 pm and Saturdays from 8:30 am-12 noon and 1:30-4:30 pm.

✔ *Principles of Health Care Education*—Introduction to principles of educational planning, development, implementation, and evaluation as applied to health care delivery settings; administering and supervising an educational program; curriculum development methodologies; principles and strategies of teaching and learning; evaluation of program effectiveness; providing support services for an educational program; identifying learning resources in a variety of health care delivery settings; and the design and implementation of continuing education programs. This is a semi-independent study course with four days of actual classroom activity. January 2 and 16, 6:30-9:30 pm; January 3 and 17, 1:30-4:00 pm.

Participants should provide evidence of leadership ability in the healthcare system. The offerings are available either for credit, audit, and/or CME credit for those with a health professional degree or its equivalent in professional training and certification. For further information on registration, contact Administrative Medicine Office, University of Wisconsin-Madison, Center for Health Sciences, 1225 Observatory Drive, Madison, WI 53706. Phone (608) 263-4889.

JANUARY 12-14, 1981: *New Therapeutics: The Results of Recent Advances in Medicine,* Telemark Lodge, Cable. Sponsored by University of Wisconsin School of Medicine; University of Wisconsin-Extension, Continuing Medical Education. Category I credit of AMA and LCCME. Fee: $210. Info: Ann Bailey, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2854.

JANUARY 15-16, 1981: First Annual Meeting of The Wisconsin Primary Health Care Association, Holiday Inn Holidome, Stevens Point, Wis. Info: Diana Lounsbury, PO Box 338, Edgar, Wis 54426.

JANUARY 15-21, 1981: Fourteenth Annual Postgraduate Course in *Gynecological Pathology, Cytogenetics and Endocrinology,* sponsored by the Medical College of Wisconsin, Milwaukee, at the Pfister Hotel and Tower, Milwaukee. Among guest faculty will be: H W Jones Jr, MD; Georgeanna S Jones, MD; J D Woodruff, MD; and Robert Young, MD (NCI). Approved for 42 cognate hours, Formal Learning, by American College of Gynecologists and meets criteria for 42 hours of credit in Category 1 for the PRA-AMA. Also approved for 42 elective hours of credit by the American Academy of Family Physicians. A $475 enrollment fee will include 68 selected 35mm slides. Registration fee is nonrefundable. Further details and registration, write to: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis. 53226.

JANUARY 18-20, 1981: *Medical/Surgical Update '81,* Telemark Lodge, Cable. Sponsored by Marshfield Clinic and Marshfield Medical Foundation. 9½ credit hours of Category 1 of the AMA-PRA approved and 9½ hours of prescribed credit of AAFP applied for. Info: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449.

11th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

January 28-30, 1981 at The Pfister Hotel and Tower, Milwaukee, Wisconsin

The Department of Family Practice, The Medical College of Wisconsin, and Southeast Chapter of the Wisconsin Academy of Family Physicians.

This three-day course will explore problems of the Acute Abdomen, Chest Pain, Thyroid Disease, Medical Ethics, and clinical updates in the fields of Radiology, Laboratory Medicine, Pulmonary Medicine, Orthopedics, Urology, and Cardiovascular Medicine. Workshops and lectures constitute the format of this seminar.

Accepted for 19 credit hours Category 1 AMA-PRA and AAFP

Fee: $160.

Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, Wis 53211. Phone: 414/291-0813.

WISCONSIN continued

JANUARY 21-23, 1981: Joint Midwest-Northlands Chapter's Annual Meeting, American College of Sports Medicine, at Telemark Lodge, Cable. Info and host: Workshop Unit-LaCrosse Exercise Program, 221 Mitchell Hall, University of Wisconsin—LaCrosse, LaCrosse, WI 54601; telephone 608/785-8686.

JANUARY 28-30, 1981: 11th Annual Winter Refresher Course for Family Physicians, The Pfister Hotel and Tower, Milwaukee. Accepted for 19 credit hours of Category I of AMA-PRA and AAFP. Info: Mrs Susanna Rechlitz, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, Wis 53211. Phone: 414/291-0813.

FEBRUARY 24-27, 1981: 8th Annual Endoscopy Conference *"Endoscopic Profile 1981: Assessment of Endoscopic Skills, Diagnostic Acumen and Clinical Judgment"*, Pfister Hotel, Milwaukee. Approved for 23 credit hours of Category I of AMA and 23 elective hours of AAFP. Fee: $300. Info: Joseph E Geenen, MD; Walter J Hogan, MD; GI Section, 8700 West Wisconsin Ave, Milwaukee 53226. Phone: 414/291-0813.

FEBRUARY 26, 1981: *Endoscopic Accessories*, Pfister Hotel, Milwaukee. Fee: $125. Info: Ms Marcia Pfeifer, RN, Course Director, Gastroenterology Consultants, Ltd, 1333 College Ave, Racine 53403.

MARCH 1-2, 1981: *5th Annual Winter Pediatric Seminar*, Caribou Lodge, Powderhorn Ski Area, Bessemer, Mich. Approved for 8 credit hours of Category I of the AMA-PRA and AAFP. Fee: $55. Info: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449.

MARCH 19-20, 1981: *5th Annual Ophthalmology Current Concepts Seminar '81*, Sheraton Hotel, Madison. AMA Category I on an hour-by-hour basis. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

APRIL 9-11, 1981: *Coronary Heart Disease 1981*, Hyatt Regency Milwaukee, Wis. Presented by St Luke's Hospital and St Luke's Hospital Foundation, Inc. Fee: $250. Approved 16 credit hours of Category I of PRA-AMA and AAFP. Info: Mrs Dorothy Black, Public Relations Dept, St Luke's Hospital, 2900 W Oklahoma Ave, Milwaukee, Wis 53215.

MAY 4-6, 1981: *Intravenous-Arteriography*. University of Wisconsin-Madison, Memorial Union, Madison. Approved 16 credit hours Category I and 16 hours American College of Radiology. Fee: $395. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone: 608/263-2856.

JUNE 4-6, 1981: *Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias*, The Performing Arts, Milwaukee. Approved 18 credit hours of Category I of PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

Section of Gastroenterology, The Medical College of Wisconsin

8TH ANNUAL ENDOSCOPY CONFERENCE "ENDOSCOPIC PROFILE 1981: ASSESSMENT OF ENDOSCOPIC SKILLS, DIAGNOSTIC ACUMEN AND CLINICAL JUDGMENT"

February 24-27, 1981, Pfister Hotel, Milwaukee, Wisconsin

The three-day conference features formal lectures, mini-group demonstrations, panel discussions, TV and motion pictures and exhibits. For the first time, our participants will test their clinical and diagnostic skills, in solving our renowned "teaching cases."

Guest Faculty: *H Worth Boyce, MD*, Tampa, Fla; *Thomas Ihre, MD*, Stockholm, Sweden; *John LoGiudice, MD*, Oak Park, Ill; *Lazlo Safrany, MD*, West Germany; *Fred Silverstein, MD*, Seattle, Wash; *Robin H Teague, MD*, Liverpool, England; *Francis Tedesco, MD*, Augusta, Ga; *Jack A Vennes, MD*, Minneapolis, Minn; *Jerome D Waye, MD*, New York, NY, and The Medical College of Wisconsin Faculty

Approved for 23 credit hours of Category I of AMA and 23 elective hours of AAFP. Fee: $300.

Info: Joseph E Geenen, MD; Walter J Hogan, MD, GI Section, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Phone: 414/291-0813.

UPPER MIDWEST

MARCH 2-6, 1981: Seventieth Annual Meeting of the United States-Canadian Division of the International Academy of Pathology, at the Palmer House, Chicago, Illinois. The Maude Abbott Lecture entitled "The Impact on Time on the Diagnosis and Treatment of Cancer: 1936-1981," will be deology," with Dr Robert T McCluskey as course director. The long course will be on "The Inflammatory Process and Infec- livered by Dr Lauren V Ackerman on March 3. Scientific papers, poster sessions, twelve specialty conferences, and 50 short courses are scheduled. A special course will be offered on "Immunopathologic Techniques in Diagnostic Pathtious Disease," with Doctors Guido Majno and Ramzi Cotran, course directors. Further info: Dr Nathan Kaufman, Secretary-Treasurer, United States-Canadian Division of the IAP, 1003 Chafee Avenue, Augusta, Ga 30904; telephone: 404/724-2973. g7-12/80

MARCH 20-21, 1981 (NEBRASKA): American College of Physicians Meeting, Omaha. Info: Bowen E Taylor, MD, Box 81009, Lincoln, NE 68501.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Toll free number 1-800/362-9080.

APRIL 6-9, 1981 (MISSOURI): 62nd American College of Physicians Annual Session, Kansas City. Info: Robert H Moser, MD, FACP, Executive Vice President, 4200 Pine St, Philadelphia PA 19104.

APRIL 30-31, 1981 (NORTH DAKOTA): American College of Physicians Meeting, Jamestown. Info: Harold W Evans, MD, 2624 Olson Drive, Grand Forks, ND 58201.

MAY 1-2, 1981 (IOWA): American College of Physicians Meeting, University of Iowa, Iowa City. Info: William B Galbraith, MD, 115 Eighth St NE, Cedar Rapids, IA 52401.

OTHERS

JANUARY 28, 1981 (HAWAII): American College of Physicians Meeting, Hilton Hawaiian Village, Honolulu, Hawaii. Info: James J Ball, MD, 1319 Punahou St, #1190, Honolulu, Hawaii 96826.

FEBRUARY 2-5, 1981 (Louisiana): *American Society for Parenteral and Enteral Nutrition,* Fifth Clinical Congress, at New Orleans Hilton, New Orleans. ASPEN is a multi-disciplinary society consisting of medical doctors, doctors of science, dietitians, pharmacists, and nurses in the field of contemporary clinical nutrition. Theme: "The Challenge of Modern Clinical Nutrition: Education, Practice and Research." Info: American Society for Parenteral and Enteral Nutrition, Inc (ASPEN), 1025 Vermont Avenue, NW, Suite 810, Washington, DC 20005 (phone: 202/638-5881). 12/80

MARCH 7-12, 1981 (COLORADO): *National Rural Primary Care Association,* fourth national conference in Denver, Colo. Info: Search Committee, NRPCA, Box 1211, Waterville, Maine 04901; Attn: Vicki Coates.

MARCH 8-15, 1981 (HAWAII): Postgraduate Course in Sports Medicine, Sheraton Hotel, Maui, Hawaii. 25 hours of Category I of AMA-PRA. Course is scheduled to coincide with the Maui Marathon to accommodate those registrants who wish to participate in the race. Info: Marianne Porter, Center for Sports Medicine, 2-063, 303 E Chicago Ave, Chicago, Ill 60611. 10-12/80

Fifth Annual GI Assistants Course Sponsored by Section of Gastroenterology, The Medical College of Wisconsin

"ENDOSCOPIC ACCESSORIES"

February 26, 1981, Pfister Hotel, Milwaukee, Wisconsin

This one day seminar will focus on the wide assortment of equipment developed for use with gastrointestinal endoscopic and procedural examinations. The course is designed to provide a comprehensive, yet practical, overview of the operation, clinical indication and use of GI procedural "tools" used by the gastrointestinal assistant.

Course is being held in conjunction with the 8th Annual Endoscopy Conference for Physicians, sponsored by The Medical College of Wisconsin, February 24-27, 1981.

Registration fee: $125.

Info: Ms Marcia Pfeifer, RN, Course Director, Gastroenterology Consultants, Ltd, 1333 College Ave, Racine, Wisconsin 53403.

AMA—1981

FEBRUARY 12-15: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9: Interim AMA House of Delegates, Las Vegas Hilton, Las Vegas, Nev.

AMA—1982

FEBRUARY 25-28: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8: Interim AMA House of Delegates, Fountainbleu Hilton, Miami, Fla. ■

AMA Hospital Medical Staff Leadership Seminars

- **Atlanta, March 27-28, 1981**
- **Washington, DC, May 8-9, 1981**
- **Chicago, September 18-19, 1981**
- **Los Angeles, November 11-12, 1981**

To identify the major problems affecting medical staffs and to maximize the leadership potential of those elected or appointed to positions of responsibility in the medical staff.

For Medical Staff leaders including: Medical Staff Officers, Department Chairmen, Committee Chairmen, Medical Directors, Directors of Medical Education, and Physician Trustees.

Faculty: Wyndham B Blanton Jr, MD, Vice-President for Medical Affairs of the Charter Medical Corporation in Richmond, Va. Jim Cathcart, professional consultant and author of the international award-winning book *Communication Dynamics.* William R Fifer, MD, President of Clayton, Fifer & Associates and is Clinical Professor at the University of Minnesota. John P Hyden, FACHA, Director of Planning and Development in the Loss Prevention Division of the Parthenon Insurance Company. John D Porterfield, MD, Senior Vice-President of Hyatt Medical Management Services, Inc. John C Render, JD, partner in the Indianapolis law firm Hall, Render & Killian. David L Schmidt, President of Management Development Associates. Jack Spalding Schroeder Jr, JD, General Counsel to the Georgia Hospital Association. Philip D Steffen, internationally recognized for professional leadership training programs. Nat T. Winston Jr, MD, Executive Vice-President of Health Care Corporation, a Chattanooga-based hospital management company.

Topics: Organizing the Medical Staff. Organizational Responsibilities of the Medical Staff. The Physician As a Medical Staff Leader. The Art of Negotiating. Effective Leadership. Accreditation Clinic. Issue Workshops. Quality Assurance.

Tuition: $375. Current AMA members pay only $250! Sessions scheduled each day from 8 am to 4 pm. Category 1 CME credit is provided on an hour-for-hour basis.

Registration to: Department of Hospitals and Health Facilities, AMA, 535 N Dearborn St, Chicago, Ill 60610.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

DHSS DEVELOPING SECOND OPINION PROGRAM. The State Department of Health and Social Services is in the process of developing a mandatory second opinion surgery program for *Medicaid* with a January 1, 1981, effective date under the direction of the 1979 Legislature.

DHSS is proposing that second opinions be required for cataract extraction, cholecystectomy, D & C, hemorrhoidectomy, hysterectomy, hip and knee joint replacement, T & A, TUR, varicose vein surgery, and inguinal hernia.

These procedures accounted for 4,655 operations last year with a total hospitalization cost of $4,874,000 and a surgical cost of $1,343,000. The Legislature hopes to "save" $500,000 through the second opinion program.

The outcome of the second opinion is not binding upon the Medicaid patient. SMS is working with DHSS in an effort to simplify the mechanics of the program.

In a related development the Dept of Health and Social Services has decided to scrap its plans for immediate establishment of its own Medicaid hospital rate review program. Some weeks ago DHSS announced it was pulling out of the Wisconsin Hospital Rate Review Program and would establish its own prospective system for establishing Medicaid hospital rates by December 1.

The Wisconsin Hospital Association had filed a lawsuit to prevent DHSS from establishing new or different hospital reimbursement rates prior to March 31, 1981, which is the date on which current hospital agreements with the state expire.

DHSS continues, however, to propose changes in hospital reimbursement after March 31 and indications are that it may seek to implement its own Medicaid rate setting program after that date.

CONSENT TO RELEASE MEDICAL INFORMATION FORM. SMS Services, Inc, has supplies of the new "Consent to Release Medical Information" form available at a price of $1.25 per hundred, plus shipping costs and sales tax. The form has been developed by SMS legal counsel as the recommended form to be used when responding to a patient or third-party request for patient care records.

HEALTH DATA REFERENCE BOOK AVAILABLE. Socio-economic data on a variety of health issues is contained in the reference publication "Health United States 1979." Published by the US Public Health Service, Office of Health Research, Statistics and Technology, this publication could provide physician speakers with valuable resource material, according to the SMS Commission on Public Information. It is available for $5.50 from the Superintendent of Documents, US Government Printing Office, Washington, DC 20402. Request DHEW Publication No. (PHS) 80-1232.

SCHEDULE SMS VIDEOTAPE PROGRAM FOR YOUR MEETING. The highlight of the SMS Leadership Conference November 14 was a videotape close-up of the activities and programs of the State Medical Society of Wisconsin. This videotape is currently available for scheduling by county medical societies, specialty societies, hospital medical staffs and other physician groups for dates after December 15. It is available on Beta, VHS, and three-quarter inch tape. Physicians should indicate which type of tape they want at the time of scheduling. For further information, contact Mike Brozek at SMS offices in Madison at 257-6781, or toll-free at 800-362-9080.

SMS ENDORSED AGENCY TOPS MILLION $ MARK. IC System, Inc, the collection agency endorsed by SMS, has just reported going over the million dollar mark in collections for SMS members. After careful investigation, SMS endorsed the IC System service in June 1978 and collections on behalf of SMS members reached $1,018,687 as of October 31, 1980, with $521,802 of that total being collected in the last 12 months. ■

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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